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Abstract

The Wyoming Department of Health, Mental Health Division is collaborating with the Wyoming Departments of Education and Family Services, as well as Wyoming's Federation of Families for Children's Mental Health (UPLIFT) and the Wyoming Association of Mental Health and Substance Abuse Centers (WAMHSAC) to develop and implement a statewide shared vision for a Child Mental Health Initiative. Federal funds are being sought for infrastructure development and service provision to continue in our process of improving the System of Care (SOC) for children with serious emotional disturbance and their families.

The Mental Health Division has played a key role of leadership in the ongoing process of developing and enhancing our SOC for children with serious mental health needs and their families. A collaborative and concerted effort amongst multiple stakeholders has progressed through various stages of SOC development in Wyoming, and we are now in a strong position to move forward to make a final decision about SOC development focus and action steps. The foundation of this process lies in the fact that broad-based consensus exists among stakeholders in the State that a SOC for children with serious mental health needs and their families should be family driven, youth guided, community based, comprehensive, and culturally and linguistically competent. We continue to maintain a focus on these key components of an effective System of Care as we move forward in our system improvements.

If funded, our Child Mental Health Initiative will support a strong focus on infrastructure development in year one, which will involve the further development of plans to implement a shared SOC vision for our State. State-local partnerships will be enhanced, collaborative efforts will be strengthened at the regional/community level, and the family's voice will be empowered. Indeed, Wyoming's Federation of Families for Children's Mental Health (UPLIFT) will play a key role in harnessing the strengths of youths and families in this initiative at the State, regional, local, and care team levels. In addition, we will maintain a strong focus on developing programs and efforts that are culturally and linguistically competent. We will develop one to two pilot sites in year one, and the Mental Health Division is committed to engaging in this process from a collaborative standpoint at all levels to ensure that plans fit unique community and regional cultures and needs. In future years, if funded, pilot regions will assist in rolling the SOC out to additional regions across the state.

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Section A: Understanding of the Project

Principles of Systems of Care for Children with SED: The Wyoming *Child Mental Health Initiative* (CMHI) seeks to create a comprehensive system of care (SOC) for youth with serious emotional disorders (SED) and their families using effective, research-based approaches. There has been broad consensus among stakeholders in the State that a SOC should be *child-centered, family-driven, community-based*, and *culturally and linguistically competent*. Additionally, stakeholders agree with the principles of a SOC described by Stroul and Friedman (1986, 1994), paraphrased here: early identification of problems; access to comprehensive, integrated, and individualized services within the least restrictive environment; care management and coordination of services that help with transitions; active participation of youth and family in treatment planning and service delivery, with protected rights and culturally competent services.

History of Systems of Care in the United States: Initiatives related to children's mental health in the U.S. date back to the beginning of the 20th Century (Lourie & Hernandez, 2003). However, the history of SOCs as understood today is more recent. Pires (2002) indicated that the first national effort in the U.S. toward creating SOC for youth with SED occurred in 1983 when Congress mandated and funded the National Institute of Mental Health's (NIMH) *Child and Adolescent Service System Program (CASSP)*. NIMH recognized that youth with SED often receive services from multiple public agencies and that more effective services require interagency collaboration. Funding and technical assistance was provided to all 50 States, several U.S. territories, and a number of local jurisdictions to plan and develop SOCs. Shortly thereafter, two national organizations emerged: the Federation of Families for Children's Mental Health and the National Alliance for the Mentally Ill Child and Adolescent Network (NAMI CAN). These organizations were (and are) strong advocates for youths and their families.

Passed in 1986 by Congress, the *State Comprehensive Mental Health Services Plan Act* required all States to develop and implement plans to create community-based service systems for both youths and adults with serious mental illness. It was mandated that family members and consumers participate in the development of State plans. In 1989, the Robert Wood Johnson Foundation funded 12 States or cities and, later, provided replication money to fund more than 15 States or localities through their *Mental Health Services Program for Youth (MHSPY)*. Legislation passed by Congress in 1992 created the *Comprehensive Community Mental Health Services for Children and Their Families Program*, which sought to develop a comprehensive array of community-based services and supports guided by a SOC philosophy. This program funded 67 States and localities and remains the major national source of funding for local SOCs.

Building SOCs occurred in urban areas due to efforts such as the Anne E. Casey Foundation, which began the *Mental Health Initiative for Urban Children*. System building efforts in this initiative occurred at the neighborhood level in inner cities, which advanced the use of "family resource centers" as the focal points for services and supports, use of "natural helpers" as partners in service delivery, and inclusion of parents and neighborhood residents as equal partners in the governance of SOCs. Specific forms of service delivery (e.g., wraparound) or types of evidence-based services (e.g., Multisystemic Therapy) have been developed, researched, and are often mandated as components of a SOC for youth and their families.

Need for Systems of Care Reform in the United States: Despite these initiatives, there still exist significant problems in SOCs. For instance, Lourie and Hernandez (2003) indicate that there is still no formal child mental health policy at the national level. Instead, services are driven by "inferred policies" taken from agencies such as child welfare, juvenile justice, special education, or adult mental health. The authors conclude that despite knowing children's needs and being able to address them, we cannot ensure the provision of services. Furthermore, parents may need to relinquish custody or children get labeled as delinquent or learning disabled in order to receive services. These issues are fully described in the President's *New Freedom Commission on Mental Health*, and recommendation 2.1 states "Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance."

A subcomponent of this issue regards differing definitions and eligibility criteria for identifying youths with SED. Anderson (2000) points out that there is no consensus among providers, researchers, or government agencies on a single definition of emotional problems. Different definitions prevent agency collaboration, communication, or both, resulting in service difficulties for youths with SED and their families (Kutash & Duchnowski, 1997). Agency definitions are driven by a particular philosophy and goals, which may be inconsistent among agencies. Also, varying definitions create the illusion that children served by one agency differ from those served by another agency. For example, education uses the Individuals with Disabilities Education Act (IDEA) definition of emotional disturbance, interpreted in the context of learning. However, mental health agencies use the DSM-IV for their definitions. The result is often service redundancy or differing, if not contradictory, recommendations. Also, different definitions can lead to varying prevalence estimates and, potentially, under-identification of youths with SED.

Other system-specific gaps or impediments to integrated services include prevention, mental health promotion, and early intervention programs (Weist, 2001). Thompson and colleagues (2002) evaluated interagency collaboration in seven North Carolina counties and found a number of barriers, including a lack of 1) State guidelines and support for collaborative efforts, 2) time and energy, 3) knowledge of other programs and agencies, 4) consistent leadership and key players for agency restructuring, and 5) administrative level collaboration between agencies, as well as 6) competition between programs and agencies and 7) restrictive confidentiality policies that limit cross-agency access to information. These barriers are, no doubt, common to many States attempting to create a SOC for children and their families. Wyoming is no exception.

Need System of Care Reform in Wyoming: Wyoming has been trying to create a SOC for youths and their families for over 10 years. This effort began in 1993 when the Director of the Wyoming Department of Health (WDH) commissioned a consultation to "develop an operational plan for a system of care for children and adolescents with emotional disturbance and their families who have multi-agency needs" (Human Service Collaborative, 1993). The consultation report made standard recommendations, such as defining the population, creating interagency teams and management structures, blended funding, addressing legal issues (e.g., relinquishment of custody), training, and legislative action, to name a few. However, at that time, the political climate in Wyoming and among child-serving Departments was such that the recommendations were not acted on, nor were there efforts to gain public support for acting on them. Soon after, there were personnel changes at all levels of State government, and activities were directed toward a myriad of other pressing system needs.

In an effort to increase community-based service systems for children, the State changed its funding policy in 1994. Medicaid mental health services were approved by the Wyoming Legislature in the mid-80s, but no new general fund was appropriated for services match. The State allocated proportional funds from each Community Mental Health Center (CMHC) annual contract amount and set these funds aside to use for the State share of the match for mental health services. In 1994, the State offered to decrease the fund proportion set aside from contract amounts (from about 40% to 15%, with the State making up the difference) to use for Medicaid match in return for CMHCs agreeing to establish increased services for children, thereby decreasing out of home/out of State placements. These services included therapeutic foster care, wraparound services, and transitional care for children heading to and returning from residential treatment and the State provided training to mental health providers in these models. However, this was not effective in increasing service capacity, or helping achieve system integration.

In late 1994, the State of Wyoming public mental health system was sued by Protection and Advocacy, Inc. and the Wyoming Alliance for the Mentally Ill (WYAMI), partly due to service inadequacies for children. As part of the litigation resolution, the Directors of the Departments of Health, Family Services, and Education signed a Memorandum of Understanding in 1998, agreeing to adopt CASSP core values and guiding principles in all program planning, care, and treatment of children. Litigation was closed in late 2001 with WYAMI and was resolved with Protection and Advocacy, Inc. in early 2002. All parties agreed to the settlement resolution with continuing work on the issues, including children system services integration.

Wyoming continues its commitment to ongoing system improvements. In August, 2001, Dr. Andres Pumariega[1] conducted a consultation about the children's services system. He made 15 recommendations, many of which were similar to those noted earlier, but with even more stress on SOC principles, structures, and procedures. He indicated that success "…will require the collaboration and ownership of many stakeholders…and the development of partnerships across agency and sector boundaries." This work is aided by the Wyoming Department of Health (WDH) structure and operations, which has an overarching framework of a Public Health Mission, under which all Divisions organize themselves. This has lent itself to service system integration within the WDH and will continue to build cross-agency integration. Also, in the past two years, Wyoming has taken several steps to develop State and local SOCs. First, the Mental Health Division (MHD) secured a community action grant from the Center for Mental Health Services (CMHS) to begin a consensus-building process among diverse State stakeholders. MHD has worked with the Western Interstate Commission for Higher Education (WICHE) Mental Health Program and 1) created and distributed to agencies and groups across the State a brochure outlining the core values and principles of a SOC, 2) held a statewide Search Conference to begin the system-building process, 3) distributed a summary of the Search Conference products to stakeholders, 4) conducted four regional meetings that built upon work at the Search Conference, and 5) conducted community readiness assessment for SOC development in 23 State counties. Summary reports were written about each part of the project[2] and informed recommendations in a statewide effort called the *Children and Families Initiative.*

[1] Professor and Director, Child & Adolescent Psychiatry, James H. Quillen College of Medicine, East Tennessee State University.

[2] Most of these documents are available at either http://www.wiche.edu/mentalhealth/SystemsofCare.asp or http://wymhd.us/initiatives/index.html#youth_system.

As described at the Department of Family Services (DFS) website, the Wyoming *Children and Families Initiative* (CFI) is the result of an act adopted by the Wyoming Legislature and signed by Governor Freudenthal in March, 2004. The CFI specifically outlines that DFS will develop a comprehensive plan to improve the lives and futures of all children and families in Wyoming. DFS will collaborate with other State and local agencies, including the Departments of Health, Workforce Services, Employment, Education, and Corrections; the Wyoming Business Council; the University of Wyoming; Wyoming Community Colleges; and the judiciary and private groups and businesses, including faith-based organizations and not-for-profit organizations that express an interest in participating in planning. This initiative will create policy direction, a strategic plan, and legislative initiatives for children and families across the entire life span.

The CFI structure consists of a Project Manager, a Steering Committee consisting of public and private leaders, legislators, judges, parents and caregivers, local leaders and other community partners appointed by the Governor, and a Sponsor Group of the Governor and Cabinet Officials. Recommendations were distributed for public comment and then communicated to the Governor and the State legislature with the first report submitted on November 1, 2004. The resultant plan has a number of wide ranging goals, including public-private partnerships, a lifespan approach to healthcare, reforming the judicial system to meet children's and family's needs, a more child and family-centered approach, to name just a few. Overall, this statewide initiative, combined with the multiple stages of SOC development activities puts Wyoming in a strong position to make final decision about SOC development focus and action steps. There is an active System of Care Steering Committee composed of stakeholders representing a wide array of child and family serving agencies and advocacy groups who are ready to move forward.

Children with SED in Wyoming to be Served: This section describes a number of demographic variables related to the population to be served through the new SOC. Among these variables are the age range of those to be served, prevalence estimates, ethnicity, gender, income level, disabilities, literacy levels, and so forth. Most of the data is presented in tables with accompanying narrative that highlights aspects of the data.

Age Range, Prevalence Estimates, Unmet Need, Payment Sources, and Income Levels: The projected age range for those to be served by the project is from birth to 21 years old. Although one is legally considered an adult at age 18, the MHD is committed to addressing problems in transitional services when adolescents become adults. This is consistent with the Individuals with Disabilities Education Act (IDEA), which requires that a free, appropriate education be given to citizens with disabilities (including mental health problems) until age 21. The MHD desires to ensure a smooth and effective transition from youth to adult services for those who need them. Table 1 provides prevalence estimates of youth with SED within Wyoming. There are three general groups identified in the data: 1) the Total Population, which includes youths in households, institutions, and group homes, 2) the household population, and 3) households under 200% poverty. Furthermore, the data concerns four age groups: 1) birth–5, 2) 6–11, 3) 12–17, and 4) 18–20. Data are also divided by gender, ethnicity, poverty level, and residence (although these numbers are based only on those age birth to 17 and exclude those 18 to 20).

Table 1: Year 2000 Prevalence Estimates of Serious Emotional Disturbance (SED) Age Birth to 20

	Total Population (HH., Inst. & Group)			Household Population			Households <200% poverty		
Youth	**SED**	**Pop**	**%**	**SED**	**Pop**	**%**	**SED**	**Pop**	**%**
Youth Total	9,502	128,873	7.37	9,366	127,975	7.32	4,285	48,905	8.76
Age	**SED**	**Pop**	**%**	**SED**	**Pop**	**%**	**SED**	**Pop**	**%**
00-05	2,829	37,226	7.60	2,802	37,003	7.57	1,507	17,226	8.75
06-11	3,102	42,589	7.28	3,102	42,589	7.28	1,365	15,458	8.83
12-17	3,571	49,058	7.28	3,462	48,383	7.15	1,413	16,220	8.71
18-20	2,607	24,106	10.81	2,087	20,705	10.08	1,097	8,670	12.65
Gender	**SED**	**Pop**	**%**	**SED**	**Pop**	**%**	**SED**	**Pop**	**%**
Male	4,857	66,236	7.33	4,795	65,882	7.28	2,099	23,862	8.80
Female	4,645	62,637	7.42	4,571	62,093	7.36	2,186	25,043	8.73
Ethnicity	**SED**	**Pop**	**%**	**SED**	**Pop**	**%**	**SED**	**Pop**	**%**
White-NH	8,135	111,747	7.28	8,054	111,310	7.24	3,507	40,287	8.71
Black-NH	72	1004	7.19	72	1,004	7.19	28	304	9.16
Asian-NH	64	655	9.84	24	331	7.38	9	97	8.87
Native-NH	321	3,809	8.42	314	3,745	8.37	208	2,199	9.44
Hispanic	910	11,658	7.80	901	11,585	7.78	534	6,018	8.87
Poverty Level	**SED**	**Pop**	**%**	**SED**	**Pop**	**%**	**SED**	**Pop**	**%**
Below 100%	1,974	19,301	10.23	1,865	18,646	10.00	1,865	18,646	10.00
100%-199%	2,431	30,340	8.01	2,421	30,259	8.00	2,421	30,259	8.00
200%+299%	2,364	33,726	7.01	2,355	33,645	7.00	0	0	0.00
300+%	2,733	45,506	6.01	2,726	45,425	6.00	0	0	0.00
Residence	**SED**	**Pop**	**%**	**SED**	**Pop**	**%**	**SED**	**Pop**	**%**
Household	9,366	127,975	7.32	9,366	127,975	7.32	4,285	48,905	8.76
Institution	97	522	18.54	0	0	0.00	0	0	0.00
Group	39	376	10.46	0	0	0.00	0	0	0.00

Statewide, youths (birth to 17) estimated to have SED is about 7.4%, while those 18 to 20 are estimated to be 10.8%. For households under 200% poverty, youths with SED is about 8.8%; for those 18 to 20 it is12.7%. Youth rates of SED for males and females are generally similar (~7.3–7.4%). Percentages are slightly higher for those under 200% poverty (~8.7–8.8%). Regarding ethnicity, Native American youth generally have higher percentages of SED than other groups. Hispanic and Black youths typically have the next highest percentages. Estimates broken down by income level shows a clear trend toward increased percentage of SED as income decreases.

Table 2 provides data regarding the number of youths served at each of the Community Mental Health Centers (CMHCs). There are 23 CMHCs in Wyoming, one per county. The data is sorted from the CMHC with the least to the most underserved youths. Twenty-one of the CMHCs have rates of 68% unserved youths or higher, with a majority (11) falling in the range of 71 to 79%. These numbers clearly demonstrate the strong need for the continued development and enhancement of the system of care for children with SED and their families in Wyoming.

Table 2: Estimated Youth in Need, Number of SED Youth Served, and Percent of Underserved for FY02 By Community Mental Health Centers in Wyoming

County	Est. Youth in Need	Total SED Youth Served	Est. Youth Underserved	% Youth Underserved
Uinta	481	381	100	21%
Goshen	226	146	80	35%
Hot Springs	79	25	54	68%
Converse	254	74	180	71%
Carbon	287	80	207	72%
Washakie	170	48	122	72%
Big Horn	249	68	181	73%
Sheridan	473	123	350	74%
Teton	259	66	193	75%
Niobrara	41	10	31	76%
Albany	439	99	340	77%
Sweetwater	782	167	615	79%
Campbell	745	160	585	79%
Weston	117	25	92	79%
Johnson	126	24	102	81%
Lincoln	325	59	266	82%
Park	469	80	389	83%
Natrona	1,288	198	1,089	85%
Platte	165	25	140	85%
Fremont	755	104	651	86%
Sublette	110	13	97	88%
Laramie	1,548	176	1,370	89%
Crook	114	9	105	92%
Totals	**9,502**	**2,160**	**7,339**	**75%**

The most recent data regarding payment sources for the youths receiving services include private insurance, Medicaid/Medicare, out-of-pocket, service contract/other agency (e.g., federally funded, other State agency), and other/none. County percentages for each source vary, but, on average, the majority of youths (44%) receiving services are covered by Medicaid or Medicare. The second highest percent (24%) is for those who receive services free. However, this figure may be somewhat inflated, as two of the counties (Uinta and Fremont) report very high percentages of youths in the "Other/None" category. If these percentages are removed, the average for the "Other/None" category is 3.5%. Taken together, private insurance and out-of-pocket payment accounts for an average of 24%. Census data regarding income in 1999 for households and families indicates that the range from $15,000 to $99,999 covers the majority of people (76.7% for households, 82.3% for families) in Wyoming. The median income for households is just under $38,000 and between $45 to 46,000 for families. The range of $25-75,000 includes 52.8% of households and 58.9% of families.

Demographic Data on Race/Ethnicity, Primary Language, and Region of Birth[3]**:** Most of Wyoming's population (98.2%) is identified as having only one race, with the rest identified as having two or more races. Caucasians represent slightly more than 92% of the population, followed by Hispanics or Latinos (6.4%) and American Indian/Alaska Natives (2.3%). Other ethnic groups represent less than 2% of the population even when taken together. However, an "other" category of ethnicity is 2.5% of the population, and those with two or more ethnic backgrounds represent 1.8%. The vast majority (93.6%) of Wyoming residents speak English only, while 6.4% speak a language other than English. Four percent speak Spanish, 1.4% speaks other Indo-European languages, and 0.5% speaks Asian or Pacific Island languages. Ninety-seven percent of Wyoming's residents were born in the United States. Those born in other countries primarily came from Latin America (40.3%), Europe (26.2%), or Asia (19.4%).

Placement and Referral Sources: In FY02, 19,237 people of all ages received a mental health service. Of the total service hours funded by State general fund dollars that year, 22% were to children ages 17 and younger. Almost 88% of these youth were living with parents or other relatives and 5.75% were living with non-related persons (Wyoming Client Information System, 2002). DFS data regarding placement of children with an Individualized Education Plan (IEP) and those in the juvenile justice system indicated that 69 placed youths had an IEP, whereas 339 were on probation. For both groups, a range of services were offered and youths often received multiple services. The list of services is too broad to present here, but they ranged from basic needs (e.g., clothing) to medical treatment, therapy, mentoring, foster care, educational services, and crisis intervention. Table 3 presents updated information (as of May 31, 2003) regarding placement in foster care, the Boy's or Girl's school, and residential treatment. Of those placed in foster care, a little over 64% were with non-relatives. About 42% of those placed in any of the settings went to the Boy's School, Girl's School, or in residential treatment. Table 4 indicates the sources of referrals to services; most were referred by either family/friends or schools.

Table 3: Placement Locations

Placement Type	Number
Boy's School	68
Girl's School	89
Foster care with a relative	220
Foster care with a non-relative	300
Long term foster care with a relative	7
Long term foster care with a non-relative	4
Specialized foster care	2
Specialized foster care with a non-relative	50
Therapeutic foster care with a relative	2
Therapeutic foster care with a non-relative	69
Residential treatment	307

Table 4: Referral Sources

Referral Source	%
Family and friends	31.0
Schools	25.4
Self referrals	7.0
Department of Family Services	6.8
Court or correction agency	3.0
Physician	3.0
Inpatient facility	0.4

(C. Shaver, personal communication, June 5, 2003).

Education Data Regarding Disabilities, Special Education, and Literacy Levels: According to an evaluation of services to young children with disabilities in 1998, the Departments of Health, Education and Family Services reported that Wyoming has identified fewer children with

[3] Based on 2000 Census data. Please go to http://quickfacts.census.gov/qfd/states/56000.html.

emotional and behavioral problems than can be expected to exist in the population, especially in the early years during which intervention can be expected to be most effective. There are two reasons for under-identification. First is the general concern about assigning a child with the label of emotional disability. Second is the lack of qualified psychologists, psychiatrists, or school psychologists with expertise in early childhood. Of the pre-school-aged children in Wyoming who are currently receiving services for a disability, there is only one child identified as having an emotional disability; however this is not identified as the child's primary disability.

According to the Wyoming Department of Education, statistics from the 2003-04 school year (December 1, 2003 enrollment count) indicate that 11,640 youths have been identified as having some type of disability (see Table 5). The largest percent (44%) of those have a learning disability, followed by speech/ language disability (26%), other health impaired (11%), emotional disability (9%), and mental disability (5%). For the official December 2003 count of students with disabilities receiving special education, 1,107 were identified as having and emotional disability (ED). The total number of students with Individual Education Plans (IEPs) was 11,640. Thus, 8.7% of students with disabilities who have an IEP were identified as having an emotional disability. Table 6 provides data on placement of these children.

Table 5: Disabilities

Disability/Impairment	Number	Disability/Impairment	Number
Learning Disability	5,118	Hard of Hearing	124
Speech/Language Disability	2,999	Traumatic Brain Injury	73
Other Health Impaired	1,225	Multiple Disabilities	96
Emotional Disability	1,017	Visual Impairment*	53
Mental Disability	608	Deafness	22
Autism	172	Deaf-Blind Disability	0
Orthopedic Disability	133	* Including blindness.	

Data regarding literacy levels for Wyoming students in grades 4, 8, and 11 for four years is based on the WyCAS, which is a statewide test that allows educators opportunities to identify areas of strength and weakness in their educational programs in order to improve teaching and learning. Public school and public institution students in grades 4, 8, and 11 take WyCAS tests each spring. The tests cover reading, writing, and mathematics. For the school year 2003 – 2004, 47%, 41%, and 50% of students in 4^{th}, 8^{th}, and 11^{th} grade, respectively, scored as proficient or advanced in their reading abilities. Thirty-five percent, 41%, and 32% of students in 4^{th}, 8^{th}, and 11^{th} grade, respectively, scored as partially proficient, whereas about 18% scored as novice in all three grades. These numbers are relatively stable across years and grades.

Services Available to Children and Adolescents with (SED): Wyoming contracts with State certified Community Mental Health Centers (CMHCs) that provide State-purchased services for children and adolescents with SED. These CMHC's are also enrolled with Medicaid to provide similar services to Wyoming Medicaid recipients. The purpose of State-purchased and Medicaid covered services is to promote full recovery from SED and uninterrupted community living by providing intensive interventions with youth and their families, involving all relevant local agencies and resources in a system of care. Services exist on a continuum that ranges from the least restrictive to most restrictive environment. Additionally, Medicaid and DFS have a blended

Table 6: School Aged Children Receiving Special Education Under the Emotional Disability (ED) Category

Educational Environment	Ages 6 – 11	Ages 12 – 17	Ages 18 - 21	Total
Outside class < 21% of day	97	176	12	**285**
Outside class 21% to 60% of day	69	227	15	**311**
Outside class > 60% of day	90	158	8	**256**
Separate public facility	7	30	1	**38**
Separate private facility	1	1	0	**2**
Public residential facility	8	10	7	**25**
Private residential facility	6	49	2	**57**
Homebound/hospital placement	2	12	0	**14**
Correctional Facility	0	29	0	**29**
Total	**280**	**692**	**45**	**1,017**

funding arrangement to contract for residential services and therapeutic foster care treatment services via Medicaid. Medicaid is also used to reimburse acute and extended psychiatric hospital stays. DFS manages the foster care programs and pays for the majority of these and a few other residential services. The DOE also places youths in residential care for educational purposes. There are a number of other Departments or programs that purchase different types of services, such as the *Children with Special Needs Programs*, *Best Beginnings* (for pregnant or new mothers), and Substance Abuse. Table 7 indicates the services provided by CMHCs to children and adolescents with SED and their families.

Table 7: Services in Wyoming for Youths with SED

Service	Details
Clinical Assessment	Evaluation of the child's or adolescent's mental health and substance problems, including functional assessment.
Agency and Community-Based Individual/Family Therapy	Mental health and substance abuse treatment services for the client, to include the family where appropriate. The service may be provided at the agency, in the client's home or in other community locations as indicated.
Psychiatric Services	Contact for the client with a psychiatrist for evaluation and for medication prescription and management.
Case Management	The non-clinical services of referring and linking a client and family to community resources and monitoring the effectiveness of resources, using advocacy to assist the client and family as necessary.
Quality of Life Funds	A limited amount of funding is available to each CMHC to assist children and adolescents with SED with emergency subsistence, prescription medication costs, obtaining health services (including dental and eye care), acquiring and retaining living quarters, transportation, respite care and recreation/socialization. Such assistance is generally one-time or temporary and is not an entitlement.
Additional Services	***In larger community mental health centers, the following additional services are usually available:***
Group Therapy	Children and adolescents with SED are treated in groups to maximize positive peer support.
Summer Day Treatment	Some CMHCs offer summer day treatment programs to provide intensive treatment and therapeutic activities for children and adolescents with SED.

Individual Rehabilitative Services	Skill training, provided individually and in a community setting, to assist clients to acquire and use independent living skills.
Therapeutic Foster Care	Some CMHCs recruit, train, and supervise adults to provide therapeutic living and interventions for children or adolescents with SED who are placed by the center in their homes. Since therapeutic foster care is considered to be a state-wide service, centers that have such homes can accept placement of youth from any county.

Collaboration with other Federal, State, and Local Programs: Wyoming's Mental Health Division is collaborating with many different public and private groups to ensure the highest level of care for children and their families in the State. Table 8 indicates current activities, which include early screening, initiatives for Native American populations, and family courts to name just a few.

Table 8: Collaborative Efforts of Wyoming's Mental Health Division (MHD)

Initiative	Activities
System of Care (SOC) Steering Committee	This committee, composed of MHD, DFS, DOH, DOE, UPLIFT, and the Wyoming Association of Mental Health and Substance Abuse Centers, works together to create a statewide community-based SOC for children with SED and their families that is culturally and linguistically competent, youth guided, and family driven.
Collaboration with UPLIFT (Federation of Families for Children's Mental Health)	MHD engages in ongoing collaboration with UPLIFT to provide resources for families of children with mental health needs, as well as family to family education, training, advocacy and support. MHD also collaborates with UPLIFT on the Statewide Family Network grant. MHD partners with UPLIFT on a daily basis to enhance and develop the system of care for children with SED and their families.
With Eagles Wings	The MHD engages in various levels of collaboration on sustainability and program development for the Circles of Care grant on the reservation.
Community Action Grant: CASSP Phase I	Received funding to begin the SOC building process; held a state-wide Search Conference to achieve consensus and begin defining goals for the SOC. The advisory council for this work is the SOC Steering Committee.
State Continuation: CASSP Phase II	Received funding to continue the SOC building process; assessed 23 counties using the Community Readiness Tool for Prevention Research to assess each county's level of readiness to provide SOC for children with SED and their families.
Program Improvement Plan	A result of the Federal Child and Family Service Review: Collaborated with DFS on committees with other State agencies, advocacy groups, elected officials, and representatives from the legal system to develop a comprehensive Program Improvement Plan designed to create better outcomes for families and children.
Children and Families Initiative	The MHD collaborates with DFS to carry out the *Children and Families Initiative*. The Deputy Administrator of the MHD is currently overseeing the work under the auspices of DFS. This Initiative is the result of an act adopted by the Wyoming Legislature and signed by Governor Freudenthal in March 2004. This initiative calls for the creation of policy direction, a strategic plan, and future legislative proposals designed to improve the lives of Wyoming's children and families.
Early Childhood Intervention	The MHD contracts with Southwest Counseling Services in Sweetwater County to place a clinician and case manager into the Child Development Center (CDC) and Head Start programs full time. Treatment services are provided through these programs and in family homes. MHD also contracts with Pioneer Counseling Center in Uinta County to provide through agency coordination and collaboration the Early Intervention Program to identify and serve pre-school children at risk for abuse and neglect, a Parent Support Group, therapy services, and early identification of at-risk parents and perinatal mothers. The MHD contracts fiscally

	with UPLIFT to implement the Wyoming Early Start Program which supports training for early childhood service providers regarding social/emotional screening and intervention. This collaboration supports Wyoming's Annual Children's Mental Health Conference and support and advocacy for children under age eight.
Maternal and Child Health	The MHD partners with Maternal and Child Health to carry out ongoing initiatives. Best Beginnings is a comprehensive, coordinated, community-based system of perinatal services for expecting moms. The program assures early and continued prenatal care and coordination of services for pregnant women and their families. Locally, collaboration takes place within the Nurse-Family Partnership program to provide outreach and prevention services for at-risk mothers and children.
Wyoming Early Childhood Comprehensive Systems Planning Grant (Child Development Training System/Family Partnerships Model)	This initiative, under the auspices of DFS and Maternal and Child Health, involves various multi-agency committees in which MHD participates. Through this collaboration, a Wyoming Child Development Training System will be developed which will use the statewide videoconferencing system to enhance the skills of providers and parents for children from birth to five years. The Family Partnerships Model will be used as a foundation for this training system. In May 2005, a summit will be held in which the working committees begin developing one strategic plan for Wyoming's children and families.
Collaboration with Wyoming Department of Education (WDE)	Collaboration with the WDE occurs through the SOC Steering Committee, where the goal is enhanced coordination of services to improve educational outcomes for children with SED, reduce out-of-home placements, and improve educational coordination when out-of-home care is appropriate.
Residential Treatment Center care	MHD works with DFS to jointly fund medically necessary treatment for children and adolescents with serious emotional disturbance.
The Juvenile Court Enhancement Initiative	Collaborated with DFS, Substance Abuse Division, Attorney General's Office, State Public Defender's Office, Court-Appointed Special Advocate, State Advisor Panel on Juvenile Justice, Prevent Child Abuse Wyoming, Wyoming Supreme Court and the Court Improvement Project to create the Family Treatment Court model and action plan, which will help the State to pilot family treatment courts.
Functional Family Therapy	The MHD contracts with Southwest Counseling to provide Functional Family Therapy, an EBP that reduces out-of-community placement, while increasing the functionality of the family for seriously delinquent and substance abusing youth. Peak Wellness is also implementing this Best Practices Model.
Mental Health Planning Council	This council has representatives from all major agencies, 51% representation from consumers and families who guide and plan our mental health system.
National Governor's Assoc. Youth Development Collaborative Grant	MHD joins with all major child interested agencies to plan for Wyoming's children's well being. This is a past effort that initiated the collaborative process in system of care development for children with SED and their families in Wyoming.
Children's Mental Health Waiver	The MHD and Medicaid are planning for a Children's Mental Health Waiver in collaboration with all child serving State agencies including Departments of Family Services, Education and Health.
Wyoming Association of Mental Health and Substance Abuse Centers (WAMHSAC)	The MHD collaborates with the members of WAMHSAC regularly to work toward a high quality system of care for children and their families.
Brief Strategic Family Therapy	The MHD contracts with Jackson Hole Community Counseling Center, Washakie Mental Health Services, and Hot Springs County Counseling Services to provide Brief Strategic Family Therapy for children at risk of mental health problems and those whose mental health problems put them at risk for out of home placement. A main strategy is participation in the development, planning, and implementation of a children's SOC through the wraparound model and the "no wrong door" concept.

Section B: Implementation Plan

Primary Goals and Objectives of the Project: The overarching goal of Wyoming's *Child Mental Health Initiative* (CMHI) is to create an accessible, effective, efficient, and sustainable system of care (SOC) for children and their families. More specifically, the State will develop infrastructure and services necessary to 1) return youth with SED currently receiving out-of-community services to their home communities and 2) prevent, whenever possible, placement of at-risk youth out-of-community by serving them in their communities. This effort is based on and guided by the core values of a SOC: child-centered and family-focused, community-based, and culturally competent services. Wyoming's plan is to initially implement SOC reform and development in two to four regions of the State, with expansion to other regions in later years of the grant. The organizational chart in Appendix 6 will serve to structure this section.

The development of the implementation plan has occurred over a several year period. In brief, development activities included an independent evaluation of the SOC overall, grant funding to build consensus, a statewide Search Conference and regional meetings with key stakeholders, statewide community readiness assessments, an active System of Care Steering Committee, and legislation creating the *Children and Families Initiative*. Family members, State and local child-serving agencies, providers, community leaders, and members of minority groups have been involved in all phases of these projects. Youth input has come from family-run or advocacy groups and satisfaction surveys.

A. Infrastructure Development: Wyoming will organize and coordinate available Federal, State, and local resources to achieve a lasting infrastructure for the SOC. As the organizational chart indicates (Appendix 6), the CMHI involves five primary groups/stakeholders: the Wyoming Department of Health (WDH), Department of Family Services (DFS), Wyoming Department of Education (WDE), Wyoming Association of Mental Health and Substance Abuse Centers (WAMHSAC), and Wyoming's Federation of Families for Children's Mental Health (UPLIFT). The organizational plan encompasses a shared state vision amongst all stakeholders which has been reached through years of collaboration within the core values of a system of care for children with SED and their families. Our vision is such that all stakeholders will play key roles in a system that is truly braided at the state level, and a similar plan will be replicated at the regional and local levels. The CMHI grant will be fiscally run through the WDH Mental Health Division, and will be overseen by the Principal Investigator, who is housed within the Mental Health Division. The Project Director will be a WDH Mental Health Division Administrator currently on loan to the Department of Family Services' Children and Families Initiative. A myriad of collaborative efforts are and will continue to be planned and implemented through the System of Care Steering Committee (SOC-SC) at the state level, and a similar structure will be replicated at the regional level. Whereas the SOC-SC engages all stakeholders in the SOC development at the State level, Local Coordinating Committees (LCCs) will be created to engage in similar fiscal management, system development and implementation activities at the regional level. At the individualized level, each child/family receiving services through the grant will collaboratively develop a care plan with various community groups/agencies and providers, and this Family Care Team (FCT) will carry out the care plan. Each FCT will be coordinated by Family Care Coordinators to ensure that all service providers on the FCT are working together smoothly to meet the child and family's needs. We plan to work together as we develop the

process of developing a formula for working toward case rates, and these rates and processes of developing these rates will be reviewed regularly by all collaborators. In addition, with regard to choosing and implementing Evidence-Based Practices such as MST and FFT, we will collaborate to design a method of analyzing the costs of implementing these models and will maintain flexibility with regard to unique financial community needs. We will allow for differences between urban centers and rural centers in Wyoming with regard to implementation of Evidence-Based Practices. Memoranda of Understanding (MOUs) have been developed and agreed to by these State agencies and groups (Appendix 1).

Systems Integration, Interagency Collaboration, Services Integration: Interagency collaboration has occurred for multiple years at the State and local levels. The primary difficulty has been integrating State-level planning with locally collaborative efforts. Thus, infrastructure development and organization will serve to integrate these efforts. At the State level, the System of Care Steering Committee's (SOC-SC) focus is moving toward a statewide community-based SOC for children with SED and their families. The SOC-SC's primary responsibilities include: 1) acting as "barrier busters" by facilitating integration of policy and funding at the State level to close gaps in the current "silo" system; 2) develop a Request for Qualifications (RFQ) announcement and selection process inviting local interagency collaborations to establish Local Coordinating Committees (LCCs); 3) review and approve RFQs; and 4) help facilitate the implementation, evaluation, and monitoring of the project in each region. The MOU among the agencies and groups that compose the SOC-SC will serve as a founding document that outlines the roles, responsibilities, and strategic planning to fund the SOC.

As barrier busters, the SOC-SC will: 1) address issues identified by State and local stakeholders that prevent implementation of an effective service delivery system, 2) ensure cultural and linguistic competence standards at State and local levels with help from experts in cultural and ethnic issues, and 3) use learning from initial projects to develop a strategic plan for development of SOCs in other areas of the State. Wherever possible, families, service provision staff, and evaluation and administration from the pilot regions will act as trainers/mentors for other areas of the State as statewide implementation occurs, using the Invest in Kids Rollout Model.

The SOC-SC will develop and distribute a RFQ to all counties in the State. The RFQ will outline basic qualifications needed to be considered as an initial pilot site for SOC development. Specifically, the RFQ will ask that applicants apply as a "region." A region may be a single county or multiple counties. The reasons for keeping flexibility in this definition are that 1) all areas of the State should be eligible, 2) the geography of the State may be more or less conducive to counties working together or alone, and 3) some counties have a history of working together, while others do not. Thus, a single county that is separated by significant geographical barriers from other counties should have no less a chance to be selected than a multi-county partnership, provided they meet the RFQ guidelines. Furthermore, an ad-hoc subcommittee of the SOC-SC will help interested areas develop their applications through consultation.

The minimum requirements of the RFQ concern Administration, Services, and Evaluation. Administratively, a given region must have an active multi-agency collaboration (i.e., meet regularly, use meetings to guide treatment and other programmatic decisions). Members of these groups must be willing to enter a legally-binding agreement (e.g., MOU) to work as a Local

Coordinating Committee (LCC). The Regional Coordinators on the LCCs serve as managers of service funding and provision, with the goal of creating wraparound services via blended funds that meet the needs of the child and family. They evaluate system gaps in services and other needs (e.g., availability of required, optional, and non-mental health services), develop and implement strategies (with the help of the SOC-SC) to overcome these gaps, and evaluate process and treatment outcomes. The proposal must include plans for implementing evidence-based practices (e.g. MST, Therapeutic Foster Care). LCCs must ensure the cultural and linguistic competence of services. The SOC-SC will review applications and select two pilot sites, then work with the sites to begin development, implementation, and evaluation processes. During the first month following the selection and establishment of pilot sites, funding will be made available to hire the following positions for each LCC: Regional Coordinator (1 FTE), Regional Care Manager (1 FTE) and Administrative Assistant (1 FTE). (The roles and responsibilities of these positions are described later.) The LCC staff will be employed as the designated local fiduciary of funding for services. In addition to LCCs, the project will utilize Family Care Teams (FCTs). A FCT is a formal collaboration of care, where providers, youths, and parents pool resources and knowledge to assess, plan, act, and monitor progress jointly. FCTs also include informal supports (e.g., probation officers, religious figures, neighbors), but they must actively treat/support the youth. The goal of an FCT is to develop an effective and individualized treatment plan. The experience of those on the "front lines" of service delivery will inform LCCs and the SOC-SC regarding ongoing care reviews. Thus, whereas LCCs serve a largely administrative function, FCTs serve a primarily clinical function.

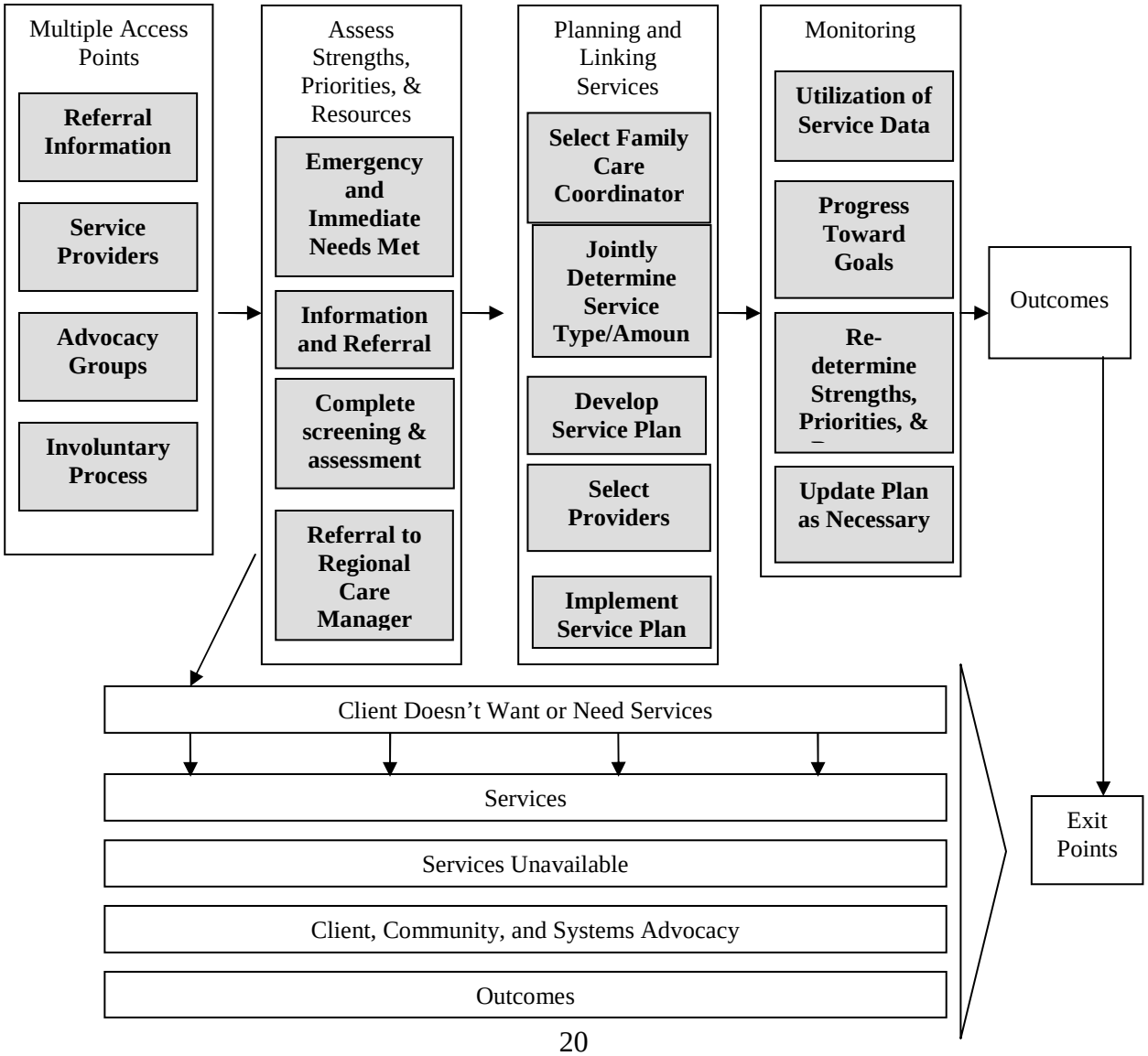
LCCs and FCTs work together to create a SOC that is responsive to community needs. This has two components: 1) developing a conceptual model of decision making that reflects broad-based community input and 2) integrating services, funding, and other functions across multiple child and family serving agencies. Consultants will conduct training on decision-making structures for integrating/providing services and assist with the process for developing the model. Successful collaboration requires training and ongoing TA regarding mediation, dispute resolution, and decision making, which will occur throughout implementation.

The interaction between the SOC-SC, LCCs, and FCTs will establish performance standards that are monitored through the Medicaid Management Information System (MMIS). The National Evaluation component of this grant provides structure and content for system and clinical outcomes, and will be used as the basis for this proposal. The primary issue is coordinating data collection and analysis among the State, regional, and local bodies. Wyoming has a State-level MIS that collects a significant amount of data already. However, the State will need to work with pilot sites to add elements into their MIS. A community office that serves as a central repository of data, meetings, and, possibly, clinical work will be identified after pilot regions are chosen.

Replication: Replication will occur after the first year of implementation at initial pilot sites, utilizing the Invest in Kids model for rollout. Lessons learned from pilot sites will inform other regions of issues worthy to consider, thereby decreasing the likelihood of encountering similar pitfalls and speeding SOC development. It is anticipated that each year subsequent to first year pilot work two new regions will be selected, using the same process described above. Also, regions not selected in the first year will have the opportunity to participate in progress updates

for initial pilot sites to allow connection to the overall effort. It is anticipated that by the end of the grant period, SOC development will have expanded to virtually all areas of the State.

Access & Wraparound Process: Wyoming will ensure that families know how and where to get services and that services are individualized. These goals are the essence of a "no wrong door" and "wraparound" approach. The flowchart below presents a schematic for Wyoming's vision of providing access and tailored treatment to youths and their families. A review of the flowchart indicates four steps in the process: 1) access, 2) evaluation, 3) service coordination, and 4) monitoring. A child may enter the system through several pathways, such as referral from various groups, service providers, or involuntary routes (e.g., court-ordered treatment). Next, a collaborative assessment process with the family will determine immediate/emergency needs, youth and family strengths/capacities, and identify the need for a referral to the Regional Care Manager. For youths and families who need multiple services, a Family Care Coordinator is then chosen by the family to help them a) determine the types and amounts of services, b) develop a service plan and select providers, then c) implement the plan. Finally, once services have begun, data is obtained regarding utilization, satisfaction, progress toward goals, periodic re-assessment of priorities or treatment goals, and updated treatment plans as needed.



Within this systematic procedure of accessing and receiving services, a number of different issues may arise at each step. First, a given youth and family may not need or want services, or may need only one particular service. In the former case, the youth and family may simply exit the system (assuming treatment is not court-ordered). In the latter case, the youth and family would receive or be referred to the needed service and would not need to go through the process described above. Assuming the youth and family require multiple services, they will be referred to the Regional Care Manager on the LCC. The Regional Care Manager will then work with the child and family to choose a Family Care Coordinator (FCC).The FCC will collaborate with the family and child to determine the types and amounts of services, i.e. wraparound. The greater number of service options, the more likely a fit with the youth and family's needs. More importantly, wraparound focuses on a family's strengths, including culture and natural supports that exist within the family, neighborhood, or community. Furthermore, the Family Care Coordinator will be the person who links the family with needed primary care, education, juvenile justice, and/or child welfare services. However, it may be that a youth and family need multiple services, but only some of those services are available. In this case, the evaluation process would identify alternative means of getting needed care or frankly discuss limitations of services with the family. Fortunately, there are advocacy and other local organizations that often provide some type of service or forum for addressing needs. Additionally, service development is meant to address these gaps and ensure as wide a range of treatment options as possible.

Funding, Number of Youth Served, & Care Review: Interagency collaboration through contributions from different child-serving agencies currently takes place in a myriad of situations in Wyoming. First, the Wyoming Department of Health (which includes the Mental Health Division, Substance Abuse Division, Developmental Disabilities Division, and Maternal and Child Health), Department of Family Services, Department of Education, and UPLIFT have all contributed nonfederal match dollars to building the SOC. For year one, it is anticipated that approximately $334,000 in nonfederal in-kind and cash contributions will be available as match for the federal grant amount. Each of these contributing agencies has one to three representatives on the SOC-SC. The MHD collaborates and fiscally contracts with Community Mental Health Centers (CMHCs), which includes monthly meetings with CMHC directors to discuss SOC development. The MHD also fiscally contracts with UPLIFT, who has committed both cash and in-kind nonfederal match. UPLIFT has played a vital role in the development of the CMHI grant planning and will continue to be highly involved in the development of the SOC. Representatives from each of the divisions indicated earlier collaborate on a daily basis with regard to federal grants and, at the local level, various multi-agency committees exist in each community. These collaborative efforts are often Safe Schools, SIG, and TANF grant committees.

The Mental Health Block Grant program in Wyoming, historically, has created new or expanded community support services to targeted populations, provide training to clinical and community support staff, and assist with data development for the block grant. Beginning 4 years ago, we began funding consumer run projects that had no ability to generate future funding, such as educational and advocacy projects sponsored by UPLIFT, Wyoming's Federation of Families for Children's Mental Health. There are also many contracts between the MHD and other agencies listed in Table 8. Also, CMHCs interested in being pilot sites will submit projected match sums.

Exemplary wraparound programs blend system funds and can, therefore, provide a flexible and comprehensive array of services. For example, as described by Kamradt (2000), Wraparound

Milwaukee “pools funds through case rates paid by the child welfare and juvenile justice systems, receives a monthly capitation payment for each Medicaid child enrolled, and coordinates other insurance and Supplemental Security Income payments to form a type of insurance pool…After all funds are pooled and decategorized, Wraparound Milwaukee can use them to cover any services that families need.”

Wyoming will utilize a similar method of blended funding to finance the SOC. During the first year of implementation, services will be funded on an expense reimbursement basis which will evolve to a case rate reimbursement method thereafter. Beginning year two, services will be purchased through a case rate from a SOC funding pool that combines funds under this grant with funds from the Departments of Health, Family Services, and Education and Medicaid fee for service. Local Coordinating Committees (LCCs) will administer the funding case rate pool across an eligible population after establishing: 1) the MIS to be used for assessments, developing the Individual/Family Services Plan (IFSP), authorizing services, and tracking expenditures; and 2) an administrative structure to monitor costs and ensure spending authorized through the IFSP is in line with the case rate. Any "profits" generated will be used to create a risk pool that can be drawn upon during periods of unusually high expenditures. Once an adequate risk pool is developed, additional "profits" will be reinvested into the system to build toward sustainability beyond federal funding. Allocating anticipated savings resulting from this method to an incentive pool which could then be paid to the LCCs based on achieving performance standards will occur. The project will also develop client profiles and clinical pathways for each profile using national models and local expertise to assist in costing the SOC and developing case rates. The pathways model will be used to assist in the development of ISFPs and will be continuously updated/modified based on evaluation of outcomes.

The LCC will partner with local DFS staff, Juvenile Probation, schools, health care providers and UPLIFT during the first 6 months of implementation to develop a strategy for identifying and admitting youth at risk of residential placement. This strategy will include 1) a public information and outreach component to educate all agencies and organizations serving children and families about the program and referral process, 2) development of a LCC protocol for intake and assessing risk of out-of-home placement, 3) formation of multiple intake committees across the region consisting of schools, probation, LCC staff, DFS staff, service providers, UPLIFT staff, and volunteers to ensure youth most in need are accepted into the program.

The SOC-SC and LCC staff will develop a priority list and phase in strategy for bringing youth back to local services. It is anticipated that during the first six months of implementation, 6 to 12 children and adolescents per month would be admitted to the program in each pilot region. This would be one to two new cases each month per Family Care Coordinator until they reach their average caseload of 10-15 children/families. Between 36 to 78 youth will be enrolled by the end of the first year of implementation. These timelines reflect experience with service development initiatives in States such as Kansas and Nebraska. It is anticipated that during the third year, the cost savings from bringing youth back and serving them in lower cost community alternatives along with additional funding potential from a Medicaid Home and Community Based Waiver will allow the project to accept 50-80 additional youth. As this cost-savings is realized, more Family Care Coordinators will be hired at the beginning of the third year. Five to six youth per month will be admitted to the program. With additional grant funding in year four, 50-80 more

youth will be enrolled using the same process. Based on the case rate, it is anticipated that the system will have the capacity to serve 150-200 youth across the pilot LCCs. Cost savings which would be reinvested to serve more children and adolescents in the pilot areas. The number of children expected to be served annually through key services is as follows: care coordination, 150-200; intensive home-based services,150-200; crisis intervention, 75-100; day treatment, 25-50, therapeutic foster care, 20-30, and respite care, 125-150.

Training/Workforce Development: Intensive training and TA around Multisystemic Therapy, Therapeutic Foster Care, Crisis Services, Wraparound/Family Partnerships, Parent/Professional Relationships, cultural competence, school mental health integration, mediation/conflict resolution, SOC development, program evaluation, and financing strategies will continue through year three. During this period, internal regional training components will be developed so that the system can provide its own training in years three through six for other areas of the State involved in replicating the project. During the third year, a comprehensive systems analysis will be conducted around cultural and linguistic competence and a strategic plan developed regarding issues such as 1) disproportionate representation of racial/ethnic groups in juvenile justice, child welfare, and mental health populations, 2) recruitment and retention of staff representing the diversity of the region who are able to speak the language of the people in that region, and 3) involvement of parents from diverse backgrounds in policy making.

Service delivery training contracts will be developed and signed in the first year of the project. These include 1) contract with Multisystemic Therapy Services, Inc. and/or Functional Family Therapy to provide training for two regional LCCs that include provider staff together with Care Coordinators, 2) contract with Boys Town to provide training on therapeutic foster care, crisis services, and intensive family preservation, 3) contract with the WICHE Mental Health Program to provide cultural and linguistic competence training, 4) contract with UPLIFT and the WICHE Mental Health Program to provide training on family-focused care and family-professional partnerships, and 5) contract with expert trainers for infant/toddler/preschool mental health prevention and promotion of early screening, assessment, and treatment. An intensive phase of training would occur in months five through twelve after implementation as new staff is hired.

Intensive wraparound training will be conducted in months 10-12 to orient local providers, advocates, and other stakeholders. During the first year, contracts will be developed and signed for wraparound training through WICHE for Mark DeKrai, who has provided wraparound training for over 10 years. The LCC staff will also attend the trainings on Family Partnerships, Multisystemic Therapy or Functional Family Therapy, therapeutic foster care, crisis services, cultural and linguistic competence, and family-focused care during year two. Since one of the goals of this project is statewide replication, each of the trainings will allow for statewide attendance and participation. By the beginning of the training phase, the Wyoming Department of Education (WDE) will develop a process for selecting school personnel to attend training and a method to reimburse for costs necessary to attend the trainings (e.g., travel, substitute teachers).

The MHD and the DDD will collaborate with DFS's Early Childhood Comprehensive Systems Planning Grant Child Development Training System to enhance providers' and parents' skills in promoting social/emotional development for children from birth to five years old. It will offer modules in infant-preschool mental health using the statewide video conferencing system. Each

participating site will have a facilitator on-site responsible for the training session and providing programmatic consultation to participants after the session at their facilities. This collaboration will include educating providers about the Family Partnerships model to enhance the capacity of service providers to meet the needs of very young children and families.

Family/Community Support and Involvement: Family advocacy groups or organizations are extremely valuable in facilitating collaboration, providing input and feedback, as well as training and support when developing a system of care that is family-driven and youth-guided. Wyoming is fortunate to have an active statewide chapter of the Federation of Families for Children's Mental Health. This organization's is UPLIFT, which began in 1990 with seed money from a community CASSP grant and incorporated as a non-profit complete with a volunteer board of directors. UPLIFT's mission is to promote the emotional health and well-being of Wyoming children and families. Their purpose is to encourage stability and success for children with or at risk of emotional, behavioral, or learning disorders at home, school, and in the community. UPLIFT serves families of children from birth to 25 years of age. They currently maintain five offices across the state, but staff members assist families regardless of their location, traveling to meet with them when necessary. Throughout their history, UPLIFT has always maintained a board membership comprised of a majority who are family members. In addition, the majority of UPLIFT staff members are family members of children with emotional and behavioral disorders.

UPLIFT family representatives have actively participated in State led efforts to develop a SOC for children and their families. Supporting UPLIFT's work with families in this frontier state is an important component in Wyoming's plan for developing the SOC. UPLIFT staff will assist with development of the regional governance structure, local Family Care Teams, administrative structures, and program evaluation. UPLIFT will assist in gathering stakeholder input from families in each of the funded pilot sites to ensure culturally and linguistically competent family involvement in implementation of the project activities. UPLIFT will recruit and train a Family Care Coordinator for each pilot site who will facilitate Family Care Teams, and provide outreach, advocacy, and evaluation assistance. UPLIFT staff will inform parents, community leaders, and professionals about goals and purposes of the project in addition to promoting its local and toll free telephone numbers for access to family support and advocacy. Staff members will be available to assist families through direct assistance, phone consultation, and e-mail.

Wyoming is committed to providing services to individuals regardless of background or disability. Stakeholders representing minority cultures will be invited to participate in State, regional, and local system-development processes, as well as hold positions in the governance bodies to be created. Clinicians from facilities that serve consumers from diverse backgrounds and consumers will be asked to provide feedback regarding the effectiveness and competence of services. Issues regarding Native American and Hispanic populations and rural health will be a core component of implementation training. Wyoming is home to the Eastern Shoshone and Northern Arapaho tribes, located on the Wind River Indian Reservation. The Mental Health Division has worked with the tribes over the last several years and will continue to obtain input and feedback on ensuring the CMHI is culturally sensitive and appropriate to both tribes. These contacts will serve as gatekeepers and will link the CMHI with other community leaders. The CMHI will respond to requests from the tribes on "nothing about us without us" and will use consultants/trainers directly from both tribes to train others on how to best work with Indian

people in Wyoming. Additionally, the Northern Arapaho Tribe was awarded a Circle of Care of grant for With Eagles Wings (WEW). WEW provides mentoring, transportation, advocacy, outreach, traditional/cultural healing, and case management to all youth on the Wind River Indian Reservation. The CMHI will consult with them about their lessons learned. The SOC-SC will work directly with the Tribal Liaison. There is also a large Spanish-speaking population in Teton County. The child serving agencies in Teton County collaborate actively with the CMHI and during infrastructure development, focused and intensive plans will be developed to address and enhance the needs of this population in a culturally and linguistically competent manner. Furthermore, on-site, specific cultural competence and diversity issues will be addressed in each of the pilot sites. As the project expands, training for clinicians will involve dissemination of cultural sensitivity related to the screening and assessment protocols.

Evaluation & Technical Assistance: Wyoming recognizes the importance of ongoing evaluation of the SOC and will comply with Section 565(c) of the Public Health Service Act by conducting 1) longitudinal studies of outcomes of the system of care, 2) related service outcomes, 3) the effect of systems of care on utilization of institutional settings, 4) barriers to or success in interagency collaboration, and 5) consumer and family views of and satisfaction with the system of care's effectiveness. In this regard, screening and assessment instruments will need to demonstrate sound psychometric properties and cultural sensitivity. The selection process will include an evaluation of the applicability of a given instrument to a wide range of people, such as individuals with learning, literacy, visual, auditory, or language barriers. That is, the instruments should have alternative administration procedures for special situations. In the event that all the instruments considered lack the scope of applicability desired, stakeholders will utilize the best instruments and determine the appropriateness of altering them to widen their applicability.

The WICHE Mental Health Program will be contracted with to provide training in cultural competence. WICHE has an extensive background in cultural competence. For instance, in partnership with SAMHSA, WICHE developed standards in mental health across different ethnicities/races[4]. WICHE coordinated the CMHS activities of four national racial/ethnic panels with 72 members from America's underserved-underrepresented racial/ethnic groups (African American, Asian American/Pacific Islander, Hispanic/Latino, and Native American). These groups produced the SAMHSA/CMHS National Standards for Cultural Competence. WICHE has close association with public mental health entities, universities, colleges, tribal colleges, and national and international educational and mental health organizations that will provide access to a large resource base for language and cultural expertise.

The State's MIS will be helpful in providing data to the National Evaluation, and will comply with the data collection and evaluation procedures indicated, hire required personnel, and participate in training or other study-related activities. Wyoming will subcontract with WICHE, who will serve as the primary project evaluators. Wyoming and WICHE will create a technical assistance (TA) plan for the SOC that involves ongoing assessment of TA needs, training activities, and create an interagency team and TA coordinator.

[4] Guidelines can be found at http://www.wiche.edu/MentalHealth/Cultural_Comp/ccs19.htm.

Social Marketing Strategies: Agencies need to have an appropriate procedure for developing an effective social marketing strategy. Rodriguez (2003) presents such a methodology, which will be described briefly here. In general, the social marketing strategy will need to sell two ideas: 1) a child's mental health is an important component to overall health and 2) SOCs help youths and their families achieve mental health. To effectively communicate these ideas, marketing strategists need to identify their mission, goals, values, and the population served by the SOC. It is particularly important to understand the beliefs and backgrounds of the target audience, and the message needs to be sent through appropriate means, often with the help of community partners who are linked more strongly to consumers and their families. A good strategy is one that has been tested and altered as needed, as determined by response and feedback. The Community Readiness Model encompasses all of these qualities, and since Wyoming has already conducted a statewide Community Readiness Assessment, the Community Readiness approach to assisting communities in developing effective social marketing strategies will be used as part of the social marketing plan.

B. Service Delivery: The MHD will coordinate with the State Departments of Education, Family Services, UPLIFT, and divisions within the Wyoming Department of Health to ensure that programs within those systems include mental health services or referral mechanisms. Youth enter the SOC in multiple ways adhering to the "no wrong door" philosophy. Youth with SED and/or substance abuse diagnoses will be referred by any of the child and family serving agencies indicated above, as well as juvenile justice, primary care, family advocacy organizations, or self-referral. Wyoming will target youth below the age of 21 diagnosed with SED or co-occurring disorders, particularly those presently in out-of-community placements or who are at risk for out-of-community placements. SED is the inclusive term for children whose emotional and mental disturbance severely limits their development and welfare over a significant period of time and requires a comprehensive and coordinated SOC to meet their needs. The project will use this definition as a baseline for eligibility. However, the definition will also include elements from other criteria (e.g., IDEA) to capture children who may not meet all SED criteria but who do require services. Eligibility for services within a given system is determined at intake or when a change in case circumstances result in a change in eligibility.

Criteria to determine whether a child has SED include: 1) child/adolescent is less than 18 years of age, 2) has a DSM IV diagnosis (or a DC:0-3 diagnosis if the child is three years of age or younger), 3) degree of emotional and mental disturbance consistently prevents him or her from functioning in at least two of the following life domains: age appropriate self-care, family life, education, community living, personal hygiene, leisure time management, and peer relationships, 4) the disorder must have been present for at least one year or is anticipated to persist for a year or longer on the basis of current (within past year) diagnosis, 5) the severity of the disorder places them at significant risk for out of school, home, or community placement.

The development of service provision components in the SOC will be an ongoing process that includes an initial assessment phase and periodic reviews. The assessment will look at current required mental health and support services, optional services, and non-mental health services in each pilot site. Service gaps will be identified and a plan will be created that 1) integrates current services and 2) develops services that are missing. Currently, 15 Community Mental Health Centers (CMHCs) provide outpatient services on a continual basis. All sites provide individual

and family therapy, case management, and crisis stabilization. Eleven of the 15 centers provide psychiatric services within one month of referral. Currently, 7 of the 15 CMHCs offer comprehensive assessment within 72 hours of referral (more than 50% of the time) and 6 provide emergency psychiatric services. The average caseload for the 21 FTE case managers is 21-25. While the majority of treatment is provided at the center, 10 sites see families at other appropriate locations (e.g., home-based visits). Seven of the centers offer therapeutic foster care and respite care. For necessary mental health services not provided by the CMHCs (e.g., residential treatment), the child/family will be referred to other providers within the SOC.
In order to provide wraparound services, non-mental health services typically complement the Individual Family Service Plan (IFSP) for a child. Agencies will make a commitment via MOU with other agencies regarding services as a working partnership agreement. The participating agencies in the SOC, when possible, will offer or refer to the following services: 1) education, 2) health, 3) substance abuse treatment and prevention, 4) vocational counseling, rehabilitation, and transition, 5) therapeutic recreational activities, and 6) protection and advocacy. As appropriate, established alternative or traditional healing practices for ethnic minority groups will be utilized.

Strategies to Implement Key Service Activities: A primary strategy to implement key service activities is to develop a uniform assessment procedure and protocol across child and family-serving agencies. The procedure is described in the flowchart and previous sections. The protocol will enable providers across agencies who are a family's first contact to identify the range of needed services for a given child and family. In essence, the assessment will be a biopsychosocial evaluation of the youth, with particular attention to family context and needs. The goal of the assessment is to identify whether or not a given child and family require multiple services and, therefore, need referral to a Regional Care Manager on an LCC.

The process for developing the assessment protocol will have several steps. First, agencies in pilot regions will submit their current intake and assessment protocols for review through a group process to evaluate commonalities and divergences. The goal is to create one tool that will be useful to providers across agencies. Second, a decision-making process will be created to identify when the use of the new assessment tool is warranted. For instance, parents seeking medical help for a child who show no need for multiple services will not undergo the assessment. Also, there will be a need to determine which agencies need to use this assessment. Using the same situation, primary care providers may not be in a position to include such an assessment in their practices (e.g., due to staff limitations). This does not mean that efforts to enable primary care to include such a tool in their practices would be abandoned; it means that some providers are going to be more or less able to do so and that the System of Care Steering Committee (SOC-SC) and Local Coordinating Committees (LCCs) will need to work with such groups to find ways to make it happen. Once the assessment tool is created, providers will be trained in its use and the referral process. Most providers will have experience with assessment, and training on the new one will involve orientation to new items of inquiry and their significance. Using the information gathered for appropriate referral to the LCC will be a major focus.

Clinical Interventions, Care Management, & Individualized Service Plans: Wyoming has detailed procedures for diagnostic and treatment planning for children with SED designed to match the specific mental health needs of the child with the most appropriate treatment or combination of treatments. The MHD created practice guidelines based on the DSM-IV that

provide a foundation to assist in the delivery of high quality, consistent clinical services (at http://mentalhealth.state.wy.us/treatment/mhcpg.pdf). Additionally, other child and family serving Departments or Divisions (e.g., Departments of Education and Family Services) have their own practice guidelines that strive toward best treatments in the most appropriate settings.

Since illness presentation does not always meet clear DSM-IV diagnostic criteria, and response to interventions is not uniform, clinicians must create Individual Family Services Plans (IFSP)for each client. An IFSP requires an assessment that identifies the uniqueness of the child and family. Most importantly, the assessment uses a recovery-based approach, which focuses on the child and family's strengths and provides a positive and hopeful framework within which families work toward treatment goals. Thus, assessments should include, but are not limited to, the following components: 1) establishing rapport; 2) the context of and reasons for referral; 3) the youth's understanding of the problem and motivation to cooperate; 4) understanding the youth's developmental functioning, including strengths and the nature and extent of behavioral, cognitive and/or emotional difficulties; 5) identifying strengths, weaknesses, and resources of the family system; 6) understanding the role of gender and/or cultural factors in behavior; 7) forming a diagnostic impression; 8) developing treatment recommendations; 9) communicating the assessment findings and recommendations to the parents and the youth; and 10) developing a plan for treatment with the youth and family. Furthermore, the individual conducting the assessment should be prepared to research or to obtain consultation on possible cultural explanations for behavior *prior* to making a final treatment decisions or making a diagnosis.

The comprehensive assessment will enable providers to work collaboratively with the child and family to create an IFSP that builds upon their existing strengths. The providers will include the child and family in the development of specific objectives that meet their unique needs and will guide the family in the creation of a methodology to meet these objectives within a reasonable timeframe. Referrals to optional and non-mental health services will be made as appropriate. In accordance with IDEA, SOC providers will include relevant school personnel so that the goals of the IEP are integrated into the IFSP. Further, in line with Title IV-B, Subpart 2, of the Social Security Act, the assessment will determine a child and family's need for family preservation, family support, time-limited family reunification, and/or adoption promotion and support services. Referrals to such services will be made upon identification of need for them.

An overarching goal of the SOC is a commitment to the preservation of the family through the provision of community-based services to promote the well-being and stability of children and families. The intake assessment will determine the youth's treatment needs and refer to the LCC Regional Care Manager as appropriate. The Regional Care Manager will assist the family in choosing a Family Care Coordinator, who will collaborate with the family to identify treatment goals, providers, and other helpful resources. Specifically, the Family Care Coordinator will work with the family to develop the Family Care Team (FCT), which is composed of the youth, parent(s), and all local formal and informal providers or supports for the family, coordinated by a Family Care Coordinator, to ensure the activities of the FCT are family-guided and youth-driven. Simultaneously, the System of Care Steering Committee (SOC-SC) and Local Coordinating Committee (LCC) will be developing or creating services that are missing in the regional SOC. In particular, regional pilot sites will have submitted in their applications for pilot site status plans for developing and implementing evidence-based practices (EBPs) such as Multisystemic

Therapy. After the pilot sites are chosen, each will convene meetings in which they will decide which EBP to develop (if it does not yet exist). SOC providers will attend regular training and supervision on a quarterly basis related to wraparound, care management service approaches, and EBPs. Further, EBPs will be incorporated into IFSPs based on the match of the EBP with the child and family's diagnostic picture. The application of EBPs to children from ethnic minority cultures may need to be altered based on differences in cultural and/or spiritual values. In such cases, consultation with local providers with the requisite experience will occur. Cultural competence in the application of EBPs will also be a part of training.
Of particular importance are adolescents with SED who have a co-occurring substance use disorder. Assessment will identify co-occurring disorders and treatment planning will include appropriate services. Children with SED who are at risk for, but have not yet developed, a co-occurring substance use disorder will be offered prevention services. Similarly, the assessment will identify comorbid medical illness and/or developmental disabilities. Literacy interventions specific for children with SED must begin as early as possible in care and learning settings.

The process for quality assurance review of services in the IFSP will occur on multiple levels. The LCC and FCT will be responsible for monitoring the care of children and adolescents served by providers within their region. They will periodically review the following: 1) utilization of services, 2) progress toward individualize treatment goals, 3) re-determine strengths, priorities, and resources, and 4) update the treatment plan as often as necessary. The Family Care Coordinator will ensure a quarterly review of the appropriateness of the IFSP, however, the FCT will maintain a policy of open review, whereby the child and/or family member, or any member of the FCT may convene a care review. The term of treatment is not determined by an arbitrary amount of time, but is guided by the needs of the child and progress toward treatment objectives.

There are several avenues available to a youth or family interested in appealing decisions made regarding the services provided. First, the Family Care Coordinator and FCT should establish an open forum that allows the child and family to express concerns or disagreements. However, if a child or parents are dissatisfied with services and/or have a complaint, they can file a grievance with a particular agency (e.g., CMHC), the LCC, and/or the SOC-SC, which will have a person designated to handle these kinds of issues. The designated person will be responsible for following up on the complaint and will communicate with the family within one week of receipt (or faster if provider negligence may cause harm). The grievance process will be executed as quickly as possible, but may vary depending on the nature of the complaint. The family may also choose to contact their local Protection and Advocacy office with a grievance.

Family-Driven Care: Family-driven care within Wyoming's CMHI means that families have a primary and decision-making role in their own care, as well as planning, implementing, and evaluating the project. Family members will be involved in every level of the system including: governance; planning, program development and implementation; training; choosing supports, services, and providers; service delivery; and monitoring outcomes. Wyoming's Federation of Families for Children's Mental Health, UPLIFT, will assist family members through parental support and advocacy, community outreach, and orientation and mentoring for family member representatives on various governance bodies. Family representatives will be on decision-making bodies (e.g., LCC, FCT) and will assist with evaluation. Advocacy organizations will also assist

in providing training to professionals regarding how to create partnerships that foster families' participation in the planning, management, and evaluation of care.

A ***key family contact*** full-time equivalent position will serve as the main contact for the SOC. This person will provide advocacy for family members of children receiving services; outreach to families of children not receiving services; and be a representative on governing bodies (e.g., Steering Committee, LCC, or FCT). Family involvement will be encouraged and funding will be provided for training, participation in and travel to meetings, and lodging if necessary. Direct support will be available in the funding of the Family Care Coordinator and other personnel.
Youth-Guided Care: The SOC will actively solicit the participation of youth in decisions about their care. To assist in this endeavor, a young adult will be appointed as the ***youth coordinator*** who will initially help form an ongoing, organized group for youth receiving services in the SOC. This individual will also be responsible for developing activities to include the voice of youth with SED and to facilitate their involvement in the planning, programming, and implementation of individualized and system level interventions. The ***youth coordinator*** will serve as a youth representative on one or more of the governing bodies and will have regular contact with the *key family contact* to assure coordination of planning and outreach efforts.

Cultural and Linguistic Competence: As stated in the Surgeon General's report on Race, Ethnicity and Culture (2001), mental heath disparities along racial, ethnic and cultural lines are significant. In compliance with Title VI of the Civil Rights Act, SOC providers will not discriminate on the basis of race, color, and national origin for participation in programs or activities. SOC participant organizations hold a philosophy of cultural competence and proficiency characterized by acceptance of and respect for individual differences, expansion of cultural knowledge/resources, and adaptations of service models to better meet the needs of diverse communities. These values are realized in the following ways: 1) dynamic cultural competency planning; 2) research regarding "best practice" models for diverse populations; and 3) state cultural competency plan with local implementation.

The SOC will adhere to consistent, culturally competent language and action in services, administration, and policy. A ***cultural and linguistic coordinator*** will provide direction and guidance to the SOC in the efforts to establish and implement the policies, practices, procedures, and structures required to support culturally and linguistically competent practice. Culturally different groups will act as integral members of the various governance bodies. Administrative, clinical, and evaluative activities will address the individualized needs of the populations served, which include cross-disability, gender, race/ethnicity, culture, language, age, sexual orientation, and literacy. SOC activities will function in compliance with the guidelines outlined in the Culturally and Linguistically Appropriate Standards in Health Care (CLAS), and those included in the Center for Mental Health Services Cultural Competence Standards publication. SOC providers will, whenever possible, include the preferred language of the family during service delivery (e.g., language services, pamphlets in native language); recognize strengths and customs of the child and family that are part of their cultural or religious heritage; and uphold culturally-sensitive organizational policies and procedures. Evaluation of cultural and linguistic competence will be assessed by outcomes such as: 1) the level of participation of ethnic and racial minorities in the governance, staffing patterns, service delivery, 2) availability and use of language services, and 3) administration of the SOC (e.g., policies and procedures). Activities

will also adhere to the Americans with Disabilities Act, and any functional barriers to service access will be removed. For instance, grant funding will provide the infrastructure for disabled persons to be involved in SOC infrastructure activities (e.g., sign language, transportation).

C. Sustainability/Linkages with Statewide Transformation Efforts and Other Relevant Federally-Funded Programs: The primary goals and objectives of the Wyoming Child Mental Health Initiative links with the *Children and Families Initiative* (CFI). As described earlier, the CFI is the result the passage of House Bill 33 by the Wyoming Legislature and signed by Governor Freudenthal in March 2004. This initiative calls for the creation of policy direction, a strategic plan, and future legislative proposals designed to improve the lives of Wyoming's children and families. The State acknowledged that its children, families and communities today are suffering, and, too often, failing. Poverty, substance abuse, poor access to healthcare and insurance, quality childcare including preschool and a continuing need for good jobs that allow families to be self-sufficient compel us to take immediate action. Thus, the SOC reform effort has the full backing of the Governor, legislature, and law.

Additionally, the goals and outcomes of this project are consistent with the grant priorities and Federal transformation efforts. Grant priorities include 1) expanding community capacity to serve children and adolescents with SED and their families; 2) providing a broad array of effective services, treatments and supports; 3) creating a case management team with an individualized service plan for each child; 4) incorporating culturally and linguistically competent practices for serving all children, youth and their families; 5) eliminating disparities related to race, ethnicity, or geographic location; and 6) promoting full participation of families and youth in service planning and in the development of local services and supports.
The six goals in the mental health transformation process described in *Achieving the Promise: Transforming Mental Health Care in America* are also addressed by this proposal.

Specific examples of partnerships include the SOC-SC, *Children and Families Initiative*, the various collaborative partnerships outlined in Table 13 (Section A) of this proposal, and numerous local partnerships identified the in community readiness assessment that was completed in the October 2004. Thus, many partnerships already exist. The primary difference is that State-level partnerships are formalized, whereas local collaborations typically are not. Local partnerships, while involving multiple agencies that meet regularly and achieve positive SOC results, tend to be ad-hoc and formed by the strong initiative of local providers who see the need to collaborate. However, in that these local providers have taken the initiative themselves to form such groups, we are confident that formalizing these relationships via MOUs will not be difficult. Furthermore, MOUs will ensure the sustainability of such partnerships beyond the grant period.

Sustainability after the grant period will be insured several ways. First, switching from an expense reimbursement system to a case rate will keep cost savings at the local level to be reinvested in SOC development activities. Activities include creating new or better services, hiring personnel, and/or increasing the number of youths and families served. A second aspect of sustainability will be nonfederal match contributions. It is expected that in year one, $334,000 of match contributions will be provided from the five major stakeholders (both in-kind and cash) and projected local match from regions that submit an RFQ to be pilot sites. In remaining years of the grant cycle, it is anticipated that match dollars will be contributed by Legislature.

Currently, a presentation is being prepared to address this need with Legislature in their Select Committee. The Mental Health Division is also applying for a children's mental health home and community based Medicaid waiver. Services available through this waiver will be part of the overall system of care. Implementation of the waiver will start with the initial pilot sites and follow the replication plan to allow for some system sustainability as the grant is implemented.

Regarding specific strategies for sustainability, there is already statewide consensus about the vision and philosophy of SOC development. This was achieved through Search conference, regional meetings, and community readiness assessment activities. It was formalized and backed by the power of law through the *Children and Families Initiative*. Given that Wyoming is one of the nation's most rural environments, mental health resources are limited, and need very dispersed, the most pressing need is to develop service delivery capacity and sustainability. This capacity must develop within a solid management infrastructure that strongly supports training and sound financing. The strategies for sustainability in this context include:

i. Building on the coordination already existing at the State and within regions to develop formal decision-making structures that integrate policy, funding, and service coordination across the child-serving agencies that includes families, service providers, and community members as equal partners in ensuring the system meets the needs of children and families;
ii. Creating the Local Coordinating Committees (LCCs) to ensure that services are individualized using a strength-based wraparound approach;
iii. Intensive training of program staff in techniques of service delivery that have been demonstrated to be effective (e.g., EBPs) with the target population;
iv. Enhancing parent involvement in the system of care through UPLIFT, including individual and system advocacy, information and referral, administering consumer satisfaction surveys, and involvement in local policy and funding development;
v. Conducting ongoing analyses and taking action to ensure the system is responsive to the rich diversity of the regions and sensitive to cultural issues.

Sustainability through coordination with other relevant federally funded initiatives (e.g., Mental Health Block Grant Program, Safe Schools, etc.) was described in a previous section. In brief, the Wyoming Departments of Health, Family Services, and Education, as well as UPLIFT, have all contributed nonfederal match dollars to building the SOC and agreed to coordinate on federal initiatives such as the Mental Health Block Grant, Safe Schools/Healthy Students, Statewide Family Network Grant, and Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grants. Representatives from each of the divisions indicated earlier collaborate on a daily basis with regard to federal grants and, at the local level, various multi-agency committees exist in each community. These collaborative efforts are often Safe Schools, SIG, and TANF grant committees.

Section C: Project Management and Staffing Plan

Applicant Organization: The Mental Health Division (MHD) in Wyoming's Department of Health is the applicant organization for this grant. The MHD exists to be a leader in providing high-quality behavioral services that anticipate and respond to the changing needs of persons served. Our strategic plan is to advocate for and participate in the development and maintenance

of a comprehensive system of mental health services and supports throughout Wyoming, which stresses independence, dignity, security, and recovery. Elements we consider essential for the continued positive evolution of the mental health system of care include consumer empowerment and leadership, stigma reduction, integrated, research-based, and culturally competent services, stakeholder-based planning and policy development, flexible funding, data-informed decision-making, mental health as a component of a healthy community, and prevention. As indicated in previous sections, MHD contracts with all of the State's CMHCs and is fiscally integrated with other Divisions within the WDH, as well as other child and family serving Departments.

Qualifications and Experience of Key Personnel

Lisa Brockman, Children's Mental Health Program Manager at the Mental Health Division, will be the **Principal Investigator** 50 % of her time for this project. Lisa has overseen the fiscal operations of the Medicaid/DFS collaborative for children in need of residential treatment, hospitalization, and/or group home placement since 1995. In addition, Lisa has engaged in case management at the State level for children and youth with serious mental health needs for five years. Lisa has been a vital participant in the system of care activities for children with SED and their families in Wyoming over the past five years. She played a key role in developing the 1998 MOU, and was an original member of the System of Care Steering Committee (originally the Behavioral Health Task Force.) She will provide for the fiscal and administrative oversight of the cooperative agreement and will also be accountable to the funded community for the proper conduct of the cooperative agreement. She may choose to be responsible for or appoint someone to act as a liaison with State officials and agencies. While Lisa is dedicating .5 FTE for this position, all of the activities in her current position are focused on system of care development.

Marilyn Patton, Deputy Administrator, Department of Family Services will be the Project Director (1 FTE). Marilyn has 28 years of experience in the mental health field, and, as an administrator in the Mental Health Division from 1995-2004, has played a key role in providing guidance and leadership throughout the ongoing process of system of care development in Wyoming. Marilyn currently oversees the *Children and Families Initiative* in the Department of Family Services and was a founding member of the System of Care Steering Committee. She will be responsible for the day-to-day oversight and implementation of the project including, but not limited to developing a comprehensive strategic plan for the proposed system of care; establishing the organizational structure; hiring staff; and providing leadership.

If funded, a **Clinical Director (1 FTE)** will be hired. This individual will have primary responsibility for ensuring that children with serious emotional disturbance and their families receive timely assessments and comprehensive treatment plans. The selection and oversight of implementation of training for all evidence-based treatment models utilized in the project will be supervised by this person.

Peggy Nikkel will serve as **Lead Family Contact (.79 FTE)**. She has served as the Executive Director of UPLIFT since 1997. She is the parent of a young adult with emotional and learning disorders. Peggy has worked closely with community members, policy makers, researchers and clinicians to improve services for children, particularly in the area of prevention and early intervention. As Lead Family Contact, Peggy will work in partnership with the project staff in all

aspects of developing, implementing and evaluating the system of care. Through strong collaborative planning she will also ensure that UPLIFT's family support services are provided to families in a way that is culturally and linguistically appropriate for each individual family. UPLIFT, the Federation of Families for Children's Mental Health in Wyoming, will assist in recruiting a **Youth Coordinator (.5 FTE).** This will be a young adult who will be an integral part of the management team. This person will be responsible, outgoing, and experienced in the realm of involvement in the system of care as a youth. S/he will be responsible for developing programs for young people to facilitate their involvement in the development of the system of care, will assume primary responsibility for developing and managing a youth organization, and other activities that will bring the voice of youth who have SED to the project. This will begin as a .5 FTE position and will increase if needed in subsequent years of the grant cycle.

Wyoming will contract with the WICHE Mental Health Program to be **Key Evaluation Staff (.5 FTE)**. They will conduct ongoing evaluations of implementation of SOC development activities, site readiness, consumer outcomes, and other relevant indicators. A collaborative venture of 15 western states, WICHE is a technical assistance and evaluation center with nearly a half-century of expertise in responding to behavioral health issues, disseminating best practices in mental health, and supporting public behavioral health systems in program evaluation, clinical performance measurement, and data driven decision support. Evaluations will be site-specific and consider inter-site commonalities in the findings. Evaluations also include written reports of the results to be disseminated to relevant parties. WICHE will also sub-contract with expert consultants in SOC system development and a Post-Doctoral Fellow through the University of Colorado Health Sciences Center (UCHSC) throughout the grant period. These positions will begin as .5 FTE for two people, and will increase if necessary as the grant progresses.

Susan Markus will serve as **Technical Assistance Coordinator (.5 FTE).** She will be a central point contact for strategizing and assessing the TA needs of stakeholders and linking these needs with ongoing TA and will create opportunities for training to meet ongoing changes in communities. She will coordinate TA in areas such as culturally competence practices and services, leadership, partnership/collaboration, strategic planning, wraparound planning, sustainability, family involvement and youth involvement. Susie will also act as the link to the national Technical Assistance Partnership. This will be a .5 FTE position and will be increased if necessary.

Liz Pfisterer, Medicaid Waiver Specialist, will be the **Social Marketing-Communications Manager (.5 FTE).** Liz played a key role in coordinating statewide efforts to successfully manage an Adult Medicaid Home and Community Based Waiver. Using this experience, Liz is currently developing the program and writing the application for the Children's Mental Health Home and Community-Based Waiver. Liz is currently engaging in a great deal of community outreach and education, consensus building, and collaborative efforts in writing the waiver. She will be responsible for developing a comprehensive social marketing/communications strategy including: a social marketing strategic plan, public education activities, and overall outreach efforts. Liz will also coordinate activities with the national communications campaign. The social marketing strategy will be developed to engage individuals that currently are not accessing mental health services such as Native Americans and families from rural and remote areas. The

business community will also be engaged as part of the economic development plan for the target areas. This will be a .5 FTE position and will be increased if necessary.
The Community Mental Health Center Directors, in collaboration with each pilot region's Regional Coordinator, will serve as the **State-Local Agency Liaisons (in-kind).** These directors play an important role in the system of care development as they assess the needs of their communities and regions and design programs and community collaborations to provide these programs, while reporting to the State Mental Health Division and legislature with regard to the issues that are being faced by Wyoming's children with SED and their families. Efforts include working to establish interagency involvement in the project's structure and process by developing and/or changing interagency agreements and other public policies relevant to the creation of the system of care. These positions will be in-kind contributions at the regional pilot sites and on Local Coordination Councils and the System of Care Steering Committee.

Timeline of Activities and Tasks: A detailed timeline of activities is presented in Appendix 6. In the interest of space, activities for each year of the grant will be summarized here.

Year 1: The first year of the grant is primarily concerned with infrastructure development, particularly regarding administrative issues. The SOC-SC and Project Director will engage in the following activities: 1) acting as "barrier busters" by facilitating integration of policy and funding at the State level to close gaps in the current "silo" system (e.g., blended funding) (months 1-12); 2) develop the RFQ announcement and selection process (months 1-2); 3) review and approve RFQs (months 4-6); and 4) help facilitate the implementation, evaluation, and monitoring of the project in each region (months 6-12); 5) a case-rate reimbursement system will be developed with all partners working together, based on information from other states that have implemented a similar plan, as well as an analysis of each community's unique financial needs. Involved collaborators will meet monthly throughout all years of the grant period. They will also coordinate the State MIS with pilot sites, help facilitate the development of interagency linkages and a common assessment protocol, and subcontract with evaluators and experts in EBPs. Hiring and training of personnel will occur in months 9-12. Pilot sites will need to work with the SOC-SC, Project Director, and other relevant individuals on these issues and be ready to implement new policies and procedures by the beginning Year 2.

Year 2: The SOC-SC will continue taking action to eliminate barriers at the policy level to successful system of care development. They will seek a Home and Community-Based Medicaid Waiver. Implementation in the first pilot sites will occur. Evaluation of process and outcomes regarding implementation, interagency collaboration, satisfaction with service provision, and cultural competence will also occur. Evaluation reports will be produced quarterly. The case-rate reimbursement system will have been implemented and cost savings will be monitored. In months 6-9, the RFQ will be re-released to identify pilot sites for Year 3. Sites will be selected, hiring and training of personnel will move forward in the same manner as the previous year.

Year 3: This year will be much like Year 2, with the additional activities of disseminating initial pilot site data and applying lessons learned to the expansion of system of care development in other regions of the State. Toward the end of this year, plans for sustainability beyond the grant period will be further articulated. Ongoing evaluation, training, and compliance with the

National Evaluation will occur. Cost savings of the case-rate reimbursement system will continue to be monitored and modified as necessary.

Years 4-6: The final three years of the grant will proceed in the same manner described for earlier years. Sustainability will become a primary focus. Much of Year 6 will be devoted to producing a comprehensive system development report based on data from all subsequent years and pilot sites.

Feasibility: Wyoming believes this project, its activities, and the timeline proposed is feasible for several reasons. First, Wyoming has spent a significant amount of time and energy evaluating and planning for system of care development. There have been multiple evaluations that have focused on the State, regional, and local systems of care. The issues are well known and the plan for development is driven by data and input from a wide-ranging group of stakeholders. Second, there already exist multi-agency collaborations at the State and local levels. Of note is that many of the local partnerships have been initiated by the child and family serving agencies without a mandate from the State government. This speaks to the strong commitment of providers in Wyoming to offer the best services possible, despite the variety of limitations that go with being a very rural State. This commitment is mirrored at the State level through the enactment of legislation that created the *Children and Families Initiative*. The Governor, legislature, and all those who work in child and family serving Departments and Divisions recognize and accept the challenge of ensuring that children will have all the resources and help they need to succeed in life. Finally, the project plan utilizes a step-by-step process for system of care development. Those who have worked on these issues for many years understand that change, while often coming slowly, moves much quicker if the procedure is systematic and capitalizes on lessons learned at each point along the way.

The Mental Health Division (MHD) office (10,835 sq. ft.) is co-located in the same building as several other Department of Health programs (Substance Abuse Division, Office of Medicaid). MHD has dedicated information technology (IT) staff and utilizes the Department of Health's web hosting services, as well as the services of a private contractor for the MHD specific web site. MHD staff are provided desktops and laptop computers with a current version of Microsoft operating system, Microsoft Office, Internet Explorer, Netscape, GroupWise email, calendar and public folders, antivirus software, color laser printers and fax machines. MHD has multiple T-1 internet connections and a firewall for added network security. There are multiple network servers (email, calendar, public folders, file server, web server, intranet, SQL databases, remote access & print servers). MHD staff has training and access to a combination of proprietary and third party software (Query Path 4.1, OmniAlert, OmniMAR, HealthSPOTLIGHT, Business Objects, SPSS, MapInfo & Metaframe XP). The current database backup solution utilizes Veritas NetBackup software to run weekly database backups. These tape backups are then taken off-site to a separate storage facility for disaster/recovery purposes.

WICHE's main facility (14,200 square feet), located in Flatiron Park, Boulder, Colorado provides 33 offices and 2 conference rooms for 32 staff members. WICHE provides its own information technology (IT) and web hosting services. Services include: 1) a desktop computers with standard WICHE software (i.e., current version of a Microsoft operating system, Microsoft Office, Internet Explorer, Netscape, Facsys fax software, Outlook email, calendar and public

folders, antivirus software); 2) network servers (Exchange email, calendar, public folders, file server, web server, intranet, SQL databases, remote access, print server, network fax server); 3) SAS and SPSS software; 4) web-based survey software; 5) color laser printers and fax machines; 6) 11 network drives; and 7) backups (network drives and servers are backed up daily, backups are taken off site weekly). Regarding internet connectivity, WICHE has a T-1 internet connection and a firewall for added network security. Staff may connect to the internet from WICHE's LAN or through dialup from home. Additionally, all WICHE servers and essential network equipment is on battery backup. This provides protection from data loss due to unexpected power events. IT services responsibilities include hardware support, network support, dialup or VPN access, user support (i.e., usage of standard WICHE software on WICHE computers, WICHE printers, and other WICHE network equipment), and telephone support.

UPLIFT operates five offices with the main office located in Wyoming's capital of Cheyenne. The other offices are located in Casper, Riverton, Greybull, and Sundance. All offices are adequately equipped with computers, phones, fax machines, and copiers. The Cheyenne and Casper offices also contain conference rooms equipped with TV/VCR, and overhead projector. UPLIFT also leases two video projectors to enhance instructional training. UPLIFT operates a virtual private network for all client data.

MHD and its business associates/contractors are required to comply with Civil Rights Act of 1964, the Wyoming Fair Employment Practices Act (Wyo. Stat. § 27-9-105 et seq.), the Americans with Disabilities Act (ADA), 42 U.S.C. 12101, et seq., and the Age Discrimination Act of 1975. Ongoing self-assessment and education efforts regarding cultural and linguistic competence will assist the MHD and its business associates/contractors in making every effort to serve children and families in a culturally appropriate manner. The MHD and its business associates/contractors adhere to applicable provisions of 42 CFR, Part 2, as well as the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Ongoing HIPAA training and evaluation assure compliance with the above mentioned regulations and laws. The WDH has an intranet with the specific purpose of assisting in these efforts.

Section D: Evaluation Plan

Evaluation Activities & Procedures: The evaluation activities and procedures of this project are primarily guided by the National Evaluation described in the RFA of this grant. The National Evaluation covers a broad range of the elements to be evaluated and, in the interest of space, will not be repeated here. However, local SOCs have their own unique elements, especially in highly rural areas such as Wyoming with significant numbers of ethnic minority individuals. Thus, although the National Evaluation will form the primary basis for Wyoming's evaluation efforts, locally-driven issues requiring tracking through evaluation will be included as appropriate.

In Wyoming, all SOC stakeholders will become knowledgeable about the six evaluation components included in the National Evaluation. This will be achieved through three primary activities: 1) assessment, 2) MIS and program evaluation development, and 3) training. The evaluation team will assess current State MIS and data sharing capability across service sectors and coordinate with regional and local level MISs. The evaluation team will conduct an assessment of the National Evaluation data elements Wyoming can collect with its existing MIS

and determine the components needed to be built into their system. These identified elements will then be added into the respective regional MIS. The project will identify a local and regional data manager who will be responsible for data entry, storage, management, analysis, and reporting. Training on navigating the MIS and on clinical outcome indicators will be available for providers, family advocates, and other SOC partners. SOC partners will produce a report that succinctly describes evaluation needs and workplans for the funding period, with annual updates.

Data derived from the National Evaluation will be used for: 1) improving the service system, 2) increasing the quality of service delivery, 3) developing local system of care policies, and 4) sustaining the system of care beyond the 6-year grant period. Improving the service system will be possible through data regarding the System of Care Assessment (e.g., current services and funding sources), the Services and Costs Study, clinical outcome and service experience data, and the Sustainability study. These sources of information provide "snapshots" of the system as it is and is becoming. The data will also specify particular aspects of system development that require more attention. The clinical outcome and service experience data will be particularly important for increasing the quality of service delivery. Since children and families are at the center of good SOC services, their feedback regarding treatment and its effectiveness will, in many ways, be the ultimate standard against which SOC development is judged.

Creating effective local policies will be informed largely through the Services and Costs Study, Sustainability Study, clinical outcome data, and Monthly Evaluation Activity Report (although a number of other pieces of data will contribute as well). These studies will highlight relationships between service expenditures and outcomes, which will suggest paths for altering and sustaining the system. Creating effective policy will need to continuously bear in mind that grant funding is time-limited, thus requiring a long-term view of system creation.

Evaluators: The State will subcontract with the WICHE Mental Health Program to undertake process and outcome evaluations. A collaborative venture of 15 western states, WICHE is a technical assistance and evaluation center, with nearly a half-century of expertise in responding to behavioral health issues, disseminating best practices in mental health, and supporting public behavioral health systems in program evaluation, clinical performance measurement, and data driven decision support. WICHE is a recognized leader in rural and frontier mental health, cultural competence, and telemedicine/web-based health. Wyoming, as a member-State of WICHE, has worked with the Mental Health Program for many years regarding Medicaid and other expenditures for services, consumer satisfaction (i.e., the Mental Health Statistics Improvement Project or MHSIP), and system of care development.

WICHE, in collaboration with the University of Colorado Health Sciences Center and the University of Arkansas for Medical Sciences, has been awarded four years of support for a rural mental health research center. The WICHE Center is one of eight Rural Health Research Centers funded by the federal Health Resources and Services Administration (HRSA) Office of Rural Health Policy. The Center is engaged in an inclusive process with partners in the WICHE West to identify potential research areas for future focus. The Center will serve as a foundation upon which to build new effective science to service initiatives. The quantitative research projects for Year 1 include identifying at-risk areas within rural America to target for depression care model adoption, determining whether and why existing care models differentially improve depression

treatment in rural and urban populations; and exploring promising hospitalization prevention strategies which have the potential to provide more funding for outpatient specialty care. WICHE is working with Wyoming, South Dakota, and Alaska to support enhanced integration of services for children with SED and their families. This work has evolved over the past several years and constitutes a major transformation of how services are organized, delivered, financed, and administered. The new SOCs require collaboration between many agencies and providers including mental health, substance abuse, education, social services, juvenile justice, and communities of faith. The WICHE Mental Health Program has completed or is in the process of implementing the following: 1) an analysis of community readiness for change to support the creation of an integrated system of care in Wyoming; 2) co-sponsorship of a conference on Systems of Care in Huron, SD, in cooperation with the SD Division of Mental Health and the SD Council of Mental Health Centers; 3) production of three web casts to support staff skill development in the System of Care approach for the SD Division of Mental Health; 4) facilitated a Children's Task Force in South Dakota that resulted in recommendations being sent to and acted upon the State's legislature; and 5) supporting a pilot community adoption of an integrated system of care in Alaska. WICHE staff members have produced numerous reports, peer-reviewed journal articles, and, most recently, are finishing the editing of *Mental Health and Rural America: 1994-2004*, a book supported through grant funding by HRSA.

Although WICHE will be the lead evaluators, local evaluators will be included to further facilitate the collection of data in the regional pilot sites. Such persons will need specialized knowledge in general statistical and research methods, children's mental health services, and writing and reporting research and evaluation findings to be disseminated to multiple public audiences, including family members, policy makers, administrators, and clinicians.

Facilities, Equipment, Materials, & Resources for Evaluation: WICHE is located in Boulder, Colorado and will supply all necessary equipment, materials, and resources (e.g., computers, software, copy machine, space, time) to conduct evaluation activities. Data collection instruments will be developed using web-based technology and appropriate statistical software (e.g., Microsoft Access, SPSS) to maintain Project databases.

Most local branches of DFS, MHD, DOE have data collection systems for the particular populations they serve. Based on the community readiness surveys, some communities share data in local inter-agency groups to guide system of care planning and service delivery. However, these data sharing efforts tend not to be formal and SOC development would formalize these informal processes. The WICHE Mental Health Program will be the primary managers of most process and outcome data including, but not limited to, data entry, storage, management, analysis, and reporting. Data already collected by State Divisions (e.g., utilization, Medicaid) will continue, as will regional pilot site data collection. WICHE, as an independent entity with extensive data management, analysis, and interpretation experience, will store and integrate relevant information in an objective manner. Information in the electronic database will be secured with password protection and only local and WICHE evaluators will have access to it.

The current Medicaid Management Information System (MMIS) has the capacity to provide a collection of detailed data, including claims data and features a desktop web-based tool that allows users to analyze the data using a Decision Support System (DSS). The DSS user interface

is very intuitive and simple to use with powerful drill down capability that allows users to get detail at the line level. Additional tables with non-claims data are available to assist in analysis of other types of information that may be required. Training and ongoing technical assistance is provided to pertinent users by the Medicaid fiscal agent (ACS). Department of Family Services is currently in discussion with ACS to process and store their non-Medicaid claims data within the MMIS as well. This arrangement will allow the two main child-serving agencies to have common data in one secure location that is accessible to all those who would need to access it.

Family Members and Youth Roles in Evaluation: The evaluation plan supports community capacity building by conducting "participatory action research," which promotes stakeholder participation, cultural competence, and data useful for management information systems. As a report from the Family Resource Coalition (1996) states, "Families are empowered when they have access to information and resources and take action to improve the well-being of children, families, and communities." The emphasis of planning in the initial year is to establish mechanisms for participation in the planning and implementation of the evaluation process and proceed in following years with the process. The overall design of the evaluation plan and participatory action research incorporates a multi-method approach of quantitative and qualitative measures to address both implementation (formative) and outcomes (summative). Families and youth will be directly involved through a variety of strategies. They will be on LCCs, the SOC-SC, and other care review boards.

Local Evaluation Activities: The implementation (formative) evaluation assesses whether SOC development is being conducted as planned. It measures how the program is or is not working, identifying its strengths and weaknesses. The purpose of this type evaluation is to assess ongoing activities to improve the project. Implementation evaluation is essential for outcome (summative) evaluations. The summative evaluation occurs during the second year when services are being implemented to assess whether the overall program's predetermined objectives have been achieved. Another measure already used in Wyoming is satisfaction with services (i.e., Mental Health Statistics Improvement Project). Examples of item content include cultural competence, family/ community involvement, service accessibility, and availability of an array of services, to name just a few.

Investigational Review Board: All research activities at the Wyoming Department of Health must have approval by the Investigational Review Board (IRB) prior to implementation. Specifically, all research will be conducted within the parameters of the Code of Federal Regulations and its sections 45 CFR 46 and 38 CFR 15, and, where applicable, 21 CFR 50 and 56. To ensure that research studies at WDH are conducted in compliance with Federal, State, and agency regulations and ethical standards regarding human research, the IRB shall review all research projects for: 1) scientific integrity, 2) risk/benefit analysis, 3) safety of human subjects, 4) ethical treatment of research participants, 5) consent and assent document quality, 6) justice and equity in selection of research subjects, and 7) investigator and research staff training.

The special vulnerability of children makes consideration of involving them as research subjects particularly important. To safeguard their interests and to protect them from harm, special ethical and regulatory considerations are in place for reviewing research involving children (45 CFR Part 46, Subpart D). The IRB must consider the benefits, risks, and discomforts inherent in the

proposed research and assess their justification in light of the expected benefits to the child-subject or to society as a whole. In calculating the degree of risk and benefit, the IRB should weight the circumstance of the subjects under study, the magnitude of risks they may accrue from the research procedures, and the potential benefits the research may provide to the subjects or class of subjects.

Section E - Literature Citations

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Section F - Budget Justification, Existing Resources, Other Support

FFY 2005 BUDGET JUSTIFICATION FOR YEAR 1 BUDGET PERIOD
YEAR ONE: OBJECT CLASS CATEGORIES

PERSONNEL **$584,857**

Job Title	Name	Annual Salary	Level of Effort	Salary Requested
Principal Investigator	Lisa Brockman	$48,000	.50	In-Kind
Project Director	Marilyn Patton	$50,000	1.0	In-Kind
Clinical Director	To Be Named	$50,000	1.0	$50,000
Lead Family Contact	Peggy Nikkel	$52,355	~~1.0~~ .79	$52,355
Youth Coordinator	To Be Named	$14,400	.30	$14,400
Technical Assistance Coordinator	Susan Markus	$38,000	.50	$19,000
Social Marketing Communications Manager	Liz Pfisterer	$40,000	.50	In-Kind
State-Local Agency Liaison	CMHC Directors in each Pilot Region	From $50-$100,000	.10	In-Kind
Regional Coordinator	1 at each LCC	$40,000	1.0 x 2	$80,000
Regional Care Manager	1 at each LCC	$38,000	1.0 x 2	$76,000
Administrative Assistant	1 at each LCC	$30,000	1.0 x 2	$60,000
Family Care Coordinator	1 at each LCC	$33,000	1.0 x 2	$66,000
			Total	**$417,755**
			Fringe Benefits (40%)	**$167,102**
			Total + Fringe	**$584,857**

Wyoming Mental Health Division (MHD) personnel time and costs related to the project will primarily be allocated to the project through the Wyoming Department of Health (WDE) indirect cost allocation plan. These costs are incorporated in the budget category of indirect costs. Direct costs associated with WDE personnel are requested under the categories of personnel or fringe benefits for eight positions: Lead Family Contact, Youth Coordinator, Technical Assistance Coordinator, Regional Coordinator, Regional Care Manager, Administrative Assistant, and Family Care Coordinator. No direct costs associated with project site personnel are requested under the category of contractual personnel and fringe benefits.

Principle Investigator: Lisa Brockman, will be half time in-kind during the grant period.

Responsibilities: Provides fiscal and administrative oversight of the grant and is accountable to the pilot sites for the proper conduct of the grant. She may choose to

be responsible for or appoint someone to act as a liaison with State officials and agencies.

Project Director: Marilyn Patton, an MHD employee currently on loan to DFS, will be full time each year of the grant.
Responsibilities: Responsible for the day-to-day oversight and implementation of the project including, but not limited to, developing a comprehensive strategic plan for the proposed SOC; establishing the organizational structure; hiring staff; and providing leadership.

Clinical Director: To Be Named, will be a full time position each year of the grant.
Responsibilities: Ensuring that children with SED and their families receive timely assessments and comprehensive treatment plans. The selection and oversight of implementation of training for all EBP models utilized in the project will be supervised by this person.

Lead Family Contact: Peggy Nikkel will be full time each year of the grant.
Responsibilities: Will participate in all aspects of implementation of the SOC and provide support services for families receiving services throughout the grant. She will also maintain the primary responsibility for working closely with families and conducting outreach efforts.

Youth Coordinator: To Be Named, will be .3 FTE each year of the grant.
Responsibilities: Developing programs for young people to facilitate their involvement in development of the SOC. Will assume primary responsibility for developing and managing a youth organization, and other activities that will bring the voice of youth who have SED to the project.

Technical Assistance Coordinator: Susan Markus will be half time each year of the grant.
Responsibilities: The central point person for strategizing and assessing the TA needs of stakeholders and linking these needs with ongoing TA. May create new opportunities for training to meet ongoing changes in the community. Will coordinate TA in areas such as culturally competent practices and services, leadership, partnership/ collaboration, strategic planning, wraparound planning, sustainability, family involvement, and youth involvement. Will be the link to the national Technical Assistance Partnership.

Social Marketing Communications Manager: Liz Pfisterer will be half time each year of the grant.
Responsibilities: Responsible for developing a social marketing/communications strategy including: a strategic plan, public education activities, and overall outreach efforts. She will also coordinate activities with the national communications campaign. The social marketing strategy will be developed to engage individuals that currently are not accessing mental health services (e.g., Native Americans and

people in rural and remote areas). The business community will be engaged as part of the economic development plan for the target areas.

State-Local Agency Liaisons: Will be the CMHC Director from a given pilot region and will contribute 10% of his/her time each year of the grant.
Responsibilities: Will work collaboratively with Regional Coordinators to establish interagency involvement in the project's structure and process by developing and/or changing interagency agreements and other public policies relevant to the creation of the SOC.

Regional Coordinators: To be named, will be full time for the entire grant period.
Responsibilities: Will serve as local fiduciary of funding for services with the goal of creating wraparound services via blended funds that meet the needs of the child and family; will establish needed interagency involvement; will ensure that evidence-based practices are developed and implemented, that services provided are culturally and linguistically competent, and will establish performance standards that are monitored through a management information system.

Regional Care Managers: To be named, will be full time each year of the grant.
Responsibilities: Will coordinate care by working with the family and multiple agencies who offer services the family and child need.

Family Care Coordinators: To be named, will be full time each year of the grant.
Responsibilities: Will handle the majority of clinical activities for children and families.

Administrative Assistants: To be named, will be full time for the entire grant period.
Responsibilities: Will coordinate meetings, trainings, and clinical appointments. Will maintain records, reports, and take on other clerical tasks.

FRINGE BENEFITS **$168,302**

For state fiscal year 2005, fringe benefits are set at 40%. Health insurance is 11.25%, FICA is 7.65%, Worker's Compensation is 3.3%, and health insurance is equal to or great than 15% so that the total is 40%. Projections of future benefits are calculated based on typical increases in salary by 3%. These calculations will be for the Lead Family Contact, Youth Coordinator, Technical Assistance Coordinator, Regional Coordinator, Regional Care Manager, Administrative Assistant, and Family Care Coordinator.

Fringe Benefits (40% x 420,755) = $168,302

TRAVEL **$22,140**

Out of State Travel
2 trips for SAMHSA Meetings for 2 Attendees

(Airfare @ $600 x 4 = $2,400) + (per diem @ $120 x 4 x 6 days = $2,880)	=	$ 5,280
Local Travel (500 miles x .24 per mile)	=	$ 120
Total	**=**	**$ 5,400**

In-State Travel

Annual Pilot Site Meeting		
Mileage- 500 miles @ .29/mi. x 20	=	$2,900
Lodging - $44/ evening 2 days x 20	=	$1,760
Per diem $23/day x 2 days x 20	=	$ 920
Total	**=**	**$16,740**
Grand Total	**=**	**$22,140**

EQUIPMENT **$5,000**

Desktop Computer & Software – The Project Director will require a desktop computer and related software to manage the project, write reports, access web-based media and curricula, monitor data, and so forth.

4 Desktop computers	=	$5,000
Total	**=**	**$5,000**

SUPPLIES **$15,000**

Office Supplies	=	$ 1,000
Software (Microsoft Word, SPSS)	=	$ 3,500
Printing & Photocopying	=	$ 2,500
Postage & Fed Ex	=	$ 500
Meeting Materials	=	$ 2,500
Training Materials	=	$ 2,500
Marketing & Outreach Materials	=	$ 2,500

CONTRACTUAL **$206,534**

CONTRACT COSTS FOR WICHE MENTAL HEALTH PROGRAM

Evaluation: Wyoming will contract with the WICHE Mental Health Program to conduct ongoing evaluations of implementation of system of care development activities, consumer outcomes, and other relevant indicators. Furthermore, WICHE will develop measures for the evaluations. These evaluations will occur at the outset of the funding period, quarterly, and annually. Evaluations will be site-specific and consider inter-site commonalities in the findings. Evaluations also include written reports of the results to be disseminated to relevant parties. WICHE will also sub-contract with expert consultants in system of care development and a Post-Doctoral Fellow through the University of Colorado Health Sciences Center (UCHSC) throughout the grant period.

Training: Wyoming will contract with the WICHE Mental Health Program to provide relevant training to project site staff and other interested stakeholders in Wyoming. WICHE will utilize consultants with expertise in implementation and effectiveness, as well as evidence-based practices to create appropriate curricula. Training includes site-specific plans for implementation of system of care interventions and better consumer outcomes and inter-site issues that can be addressed at annual meetings and/or more frequent training sessions. Training will also include issues specific to consumers, families, advocacy groups (e.g., UPLIFT).

PERSONNEL **$70,141**

WICHE Mental Health:				
Job Title	Name	Annual Salary	Level of Effort	Salary Requested
Project Coordinator	Dennis Mohatt, MA	$94,638	.10	$9,464
Data & Tech Support	Chuck McGee, MA	$62,328	.25	$15,582
Evaluation Coordinator	Scott Adams, PsyD	$57,491	.35	$20,122
Training Coordinator	Mimi Bradley, PsyD	$48,000	.35	$16,800
Support Staff	Jenny Shaw	$40,866	.20	$8,173
			Total	**$70,141**
			Fringe	**$25,040**
			Total + Fringe	**$95,181**

Project Manager/Coordinator: Dennis Mohatt, M.A., Director of Western Interstate Commission for Higher Education Mental Health Program will contribute 10% of his time to the grant project during the first three years, then 5% for years 4, 5, and 6.
Responsibilities: Oversee day-to-day project activities; methodology development; budget oversight; supervision and coordination of data management, training and evaluation personnel; synthesis of ongoing and final report; coordination of trainings and evaluation.

Data Manager: Chuck McGee, M.A., will devote 25% of his time to the grant project for the first three years, 10% in years 4, 5, 6.
Responsibilities: Monitor sites for data compliance; analysis and synthesis of findings; write fidelity and outcomes reports. He will provide technical and consulting support for evaluation component including development of needed assessment instruments and database. Mr. McGee will also provide statistical analysis and data management expertise.
Evaluation Coordinator: Scott Adams, Psy.D., will contribute 20% of his time to the grant project for the first three years and 10% for years 4, 5, 6.
Responsibilities: Evaluation and data analysis; integrated report writing, meetings, and continuing education. Dr. Adams will monitor and evaluate consumer

outcomes, and initiate further evaluations (e.g., consumer satisfaction, family involvement).

Training Coordinator: Mimi Bradley, Psy.D., will contribute 20% of his time to the grant project for the first three years and 10% for years 4, 5, 6.
Responsibilities: Coordination of training activities, report writing, assessment of training outcomes, curriculum development, and continuing education. Dr. Bradley will monitor and training outcomes, and evaluate satisfaction with training.

Support Staff: Jenny Shaw will contribute 33% of her time to the grant project over the first three years and 5% in years 4, 5, and 6.
Responsibilities: Provide administrative assistance and data entry services for Project staff. Coordinate dates, times, and locations of meetings and distribute notices or announcements. Maintain documentation of meetings pertaining to the project and distribute as needed. Complete data entry from evaluation instruments as well as other word processing and clerical tasks for the Project.

FRINGE BENEFITS **$25,040**

Regular fringe benefits for WICHE Mental Health range from 32.4% (2005) to a projected 39.9% (2010) based on Federal rate (WICHE's rate is slightly higher); vacation benefits are approximately 3.3% in addition. Benefits include: Health & Dental ($550 per year for comprehensive health); TIAA/CREFF Retirement (matched by WICHE up to 10% income); Workman's Compensation; Disability, Life, & Travel Accident Insurance; Unemployment; Staff Development; Sick Leave Conversion Benefit.

Fringe Benefits		
101,699 @ 35.7%	=	$25,040

TRAVEL **$10,170**

Inter-State Travel –
Annual and training meetings for 6 Attendees (WICHE staff and consultants):

Annual and Training Meetings		
Mileage - .405 x 300 miles x 2 vehicles x 6 trips	=	$1,458
Lodging - $55/evening 2 days x 6 x 6 trips	=	$3,960
Per diem -$44/day x 3 days x 6	=	$4,752
Total		**$10,170**

TRAINING AND EVALUATION **$26,050**

Training and evaluation costs include training stipends for project site staff and stakeholder groups (e.g., Providers, UPLIFT, Steering Committee). However, since

project site staff attending the training will require coverage, funds have been allocated for this purpose.

Wyoming Pilot Staff Training Stipend ($200/day for 8 staff) x 2 days (year 1) x 4 trainings	=	$12,800
Coverage for Pilot Staff ($125/day for 8 relief staff) x 2 days (yr 1) x four trainings	=	$ 8,000
Total	**=**	**$20,800**

Stakeholder Training Stipend:
($175/day for 3 people each group) x 2 days

UPLIFT	=	$1,050
Steering Committee	=	$1,050
Others (up to 3 groups)	=	$3,150
Total	**=**	**$5,250**

Total Training and Evaluation = $26,050

EQUIPMENT **$1,446**

Long Distance/Fax/Telephone – These pieces of equipment are essential to communication within and outside of the State, so that information can be rapidly transmitted to relevant groups. WICHE Mental Health, as the primary evaluators and coordinators of training, will need this equipment to facilitate their efforts.

Long Distance/Fax	=	$ 600
Telephone	=	$ 846

SUPPLIES **$22,715**

Pilot Training and Start-Up Evaluation Materials – Baseline training and start-up evaluation materials will need to be developed and distributed to establish baseline operations and outcomes. Initially, 8 staff will be trained in Phase I of the pilot study.

8 people x $25.00 per person	=	$200

Other Training and Evaluation Materials – The creation of measures related to fidelity, consumer outcomes and satisfaction, and cultural competence will need to be created and distributed to be used for training and evaluation purposes.

2 sites x 52 weeks x $52.86 per week	=	$5,498

Office Rent, Computer/Internet/Network – Office rent is based on the percentage of time spent on the project in the context of rental agreements with the overall WICHE interstate compact main facility. These rental agreements also involve telephone service and computer/network/internet service and support.

Office Rent	=	$ 9,900
Computer/Network/Internet	=	$ 5,797
Total	=	$15,697

Office Supplies – The cost estimate is based on the costs of supply expenses for one full-time staff incurred with similar projects.

Office Supplies	=	$ 240

Postage – Expenditures associated with correspondence to consumers/family members involved with the Project and the mailing of project-related materials and reports. The cost estimate is based on costs incurred with other similar projects.

Postage & Fed Ex	=	$ 720

Printing & Photocopying – Printing includes the copying of Project reports and other documents. It is anticipated that reports will be distributed within the state to the programs, DMH, and relevant stakeholders. Dissemination plans also include reports and presentations at conferences, regional meetings, and training events. The cost estimate is based on costs incurred with other similar projects.

Printing & Photocopying	=	$360
Total Supplies	**=**	**$22,715**

CONSULTANTS **$23,000**

Consultants: Two consultants (to be named) will each contribute 40 hours the first year, 80 hours years 2 and 3, 40 hours year 4, and 16 hours year 5. Consultants will provide expertise regarding training, implementation, and evaluation. Additionally, a Post-Doctoral Fellow will be subcontracted and contribute 100% of his/her time for the first three years, 25% in year 4, then 10% in year 5.

Consultants:

Two for 3 days each @ $1,000/day	=	$6,000
Post Doctoral Fellow – To Be Named	=	$17,000
Total Consultants	**=**	**$23,000**

CONSTRUCTION COSTS		**$-0-**
OTHER COSTS		**$-0-**
WICHE DIRECT COSTS	= $178,562	
WICHE DIRECT COSTS	$178,562	
INDIRECT RATE REQUESTED	15%	
WICHE INDIRECT COSTS	$26,784	
TOTAL WICHE MENTAL HEALTH PROGRAM COSTS	$206,534	
TOTAL WYOMING COSTS	$626,997	
Total Direct Costs	$832,343	
Indirect Rate Requested	20%	
Indirect Costs Requested	$166,469	
TOTAL COSTS		**$1,000,000**

Administrative costs are allocated based on the Wyoming Department of Human Services cost allocation plan, as approved by the U.S Department of Health and Human Services. The State agrees that not more than what is identified here will be expended for administrative purposes.

CALCULATION OF FUTURE BUDGET PERIODS

(Based on First 12-month Budget Period)

Personnel	1st 12 Month Period	2nd 12 Month Period	3rd 12 Month Period	4th 12 Month Period	5th 12 Month Period	6th 12 Month Period
Personnel	$417,755	$712,288	$1,015,657	$1,046,127	$795,511	$531,376
Fringe Benefits	$167,102	$284,915	$406,263	$418,451	$318,204	$212,551
Travel	$22,140	$22,140	$22,140	$22,140	$22,140	$22,140
Equipment	$5,000	$5,000	$5,000	$2,500	$-0-	$-0-
Supplies	$15,000	$15,000	$15,000	$10,000	$5,000	$-0-
Total	**$626,997**	**$1,039,343**	**$1,464,060**	**$1,499,218**	**$1,140,855**	**$766,067**
Contractual Costs:						
WICHE						
Personnel:						
-Project Coordinator: Mohatt	$9,464	$9,795	$10,183	$5,246	$5,430	$5,620
-Data & Tech Support: McGee	$15,582	$16,127	$16,692	$6,910	$7,152	$7,403
-Eva Coordinator: Adams	$20,122	$20,826	$21,555	$12,748	$13,195	$6,828
-Training Coordinator: Bradley	$16,800	$17,388	$17,997	$10,644	$11,016	$5,701
-Support Staff: Jenny Shaw	$8,173	$8,459	$8,755	$2,266	$2,345	$2,427
Fringe Benefits	$25,040	$27,078	$29,153	$13,991	$15,068	$11,192
WICHE Subtotal Personnel & Fringe Benefits	**$95,181**	**$99,673**	**$104,335**	**$51,805**	**$54,206**	**$39,171**
Consultants:	$6,000	$6,000	$-0-	$-0-	$-0-	$-0-
Post-Doctoral Fellow: TBN	$17,000	$17,000	$10,000	$10,000	$10,000	$-0-
WICHE Subtotal Subcontract/Consultant	**$23,000**	**$23,000**	**$10,000**	**$10,000**	**$10,000**	**$-0-**
Travel	$10,170	$10,170	$10,170	$5,085	$5,085	$2,543
Training & Evaluation	$26,050	$26,050	$26,050	$13,025	$13,025	$6,513
Equipment	$1,446	$1,446	$1,446	$723	$723	$362
Supplies	$22,715	$22,715	$22,715	$11,358	$11,358	$5679
WICHE TRAVEL, TA, EQUIP.,SUPPLIES	**$60,381**	**$60,381**	**$60,381**	**$30,191**	**$30,191**	**$15,097**
Construction	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
Other	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
TOTAL WICHE DIRECT COSTS	**$178,562**	**$183,054**	**$174,716**	**$91,996**	**$94,397**	**$54,268**
Subcontract Indirect Costs (15%)	$26,784	$27,458	$26,207	$13,799	$14,160	$8,140
Subtotal	**$205,346**	**$210,512**	**$200,923**	$105,795	$108,557	$62,408
WYOMING COSTS	**$626,997**	**$1,039,343**	**$1,464,060**	**$1,499,218**	**$1,140,855**	**$766,067**
Total	**$832,343**	**$1,249,855**	**$1,664,983**	**$1,605,013**	**$1,249,412**	**$828,475**
Department Indirect Costs (20%)	**$166,469**	**$249,971**	**$332,997**	**$321,003**	**$249,883**	**$165,695**
TOTAL Grant	**$998,812**	**$1,499,826**	**$1,997,980**	**$1,926,016**	**$1,499,295**	**$994,170**

* These project estimates may change, either upwards or downwards as determined by evolving needs and progress.

Section G - Biographical Sketches and Job Descriptions

BIOGRAPHICAL SKETCH

Name: Lisa Brockman, RN	**Title:** Medicaid Program Specialist
Organization: Wyoming Department of Health, Mental Heath Division	

Institution	Degree	Year	Field of Study
Laramie County Community College	ADN	1993	Nursing

EMPLOYMENT

1995-Present Wyoming Department of Health, Mental Health Division, Medicaid Program Specialist, Child/Adolescent Services Liaison (Cheyenne, WY)
1994-1995 United Medical Center-West, Behavioral Health Unit, Utilization Review and Discharge Planning (Cheyenne, WY)
1993-1994 United Medical Center-West, Oncology Unit, Charge Nurse (Cheyenne, WY)
1990-1993 F. E. Warren AFB, O.C., Events Coordinator (Cheyenne, WY)
1985-1987 Sweetwater County Department of Family Services, Homemaker Assistant/CPS Families (Rock Springs & Green River, WY)
1981-1983 Perkins, Arthur & Keith County Services (PAKS), Inc., Coordinator of Client Support Services (Ogallala, NE)

APPOINTMENTS

2003-Present Governor's Early Intervention Council

OTHER PROFESSIONAL ACTIVITIES

2001-Present System of Care Steering Committee
2001-Present National Association of State Mental Health Program Directors
1995-2001 National Association of Surveillance Officials
1994-2002 Association of Behavioral Health Utilization Review Professionals

BIOGRAPHICAL SKETCH

Name: Marilyn Patton, M.S.W. **Title:** Assistant Deputy for the Children & Families Initiative
Organization: Wyoming Department of Family Services

Institution (Name, City, State)	Degree	Year	Field of Study
Skidmore College Saratoga Springs, NY	BS	1977	Psychology
SUNY at Albany School of Social Welfare Albany, NY	MSW	1982	Administration and Direct Practice

EMPLOYMENT

2004-2005	Department of Family Services, Children and Families Initiative
1997-2004	Wyoming Department of Health, Mental Health Division, Deputy Administrator
1995-1997	Administrator, Division of Behavioral Health
1995-2001	Member and Administrator, Partnership for the Resolution of Mental Health Issues in Wyoming
1995-2002	Mental Health Program Consultant, Division of Behavioral Health
1991-1995	Program Manager and Outpatient Psychotherapist, Southwest Counseling, Rock Springs, Wyoming
1990-1992	Outpatient Psychotherapist, Southwest Counseling, Rock Springs, Wyoming
1989-1991	Consultant and Private Practitioner, Albany, New York
1982-1989	Partner, A-League Enterprises, Albany, New York
1986-1987	Consultant-Facilitator, N.Y.S. Department of Labor, Displaced Homemaker Program, Albany, New York
1983-1986	Executive Director, OASIS, Inc., Saratoga Springs, New York
1979-1983	Educational Consultant and Staff Trainer, Bureau of Training and Resource Development, N.Y.S. Division of Substance Abuse Services
1977-1979	Coordinator of Patient Support Services, Warren Washington Community Mental Health Center

BOARD MEMBERSHIPS

1997-2000	Board of Directors; Stagecoach Drop-In Center, Cheyenne, Wyoming

APPOINTMENTS

1997-Present	University of Wyoming, Adjunct Faculty, College of Health Sciences, Division of Social Work
1989	Hudson Valley Community College, Adjunct Faculty, Humanities and Social Services
1987-1989	Hudson Valley Community College, Adjunct Faculty, Public and Community Services
1979-1989	Adirondack Community College, Adjunct Faculty, Social Sciences

OTHER PROFESSIONAL ACTIVITIES

2004	*Making a Difference Award*, UPLIFT
1998-1999	Fellow, Regional Institute for Health and Environmental Leadership, Wyoming, Department of Health Sponsorship
1982	M. S. W. Graduation Speaker – Student Selected
1974-1977	Ford Foundation Scholar, Skidmore College

BIOGRAPHICAL SKETCH

Name: Susan Markus, MS, LPC		**Title:** Child Mental Health Consultant	
Organization: Wyoming Department of Health, Mental Heath Division			
Institution (Name, City, State)	**Degree**	**Year**	**Field of Study**
University of Wyoming, Laramie, WY		1995-1997	Doctoral Program in Counselor Education
University of Wyoming, Laramie, WY	M.S.	1991	Counselor Education
University of Wyoming, Laramie, WY	B.S.W.	1986	Social Work
Laramie County Community College, Cheyenne, WY	A.A.S.	1984	Sociology

EMPLOYMENT

1998-Present Wyoming Department of Health, Mental Health Division, Consultant Children's Mental Health, Olmstead, and Community Readiness for Methamphetamine Prevention (Cheyenne, WY)

1998-Present Colorado State University, Tri-Ethnic Center for Prevention Research, Community Readiness Consultant (Ft. Collins, CO)

1998-2004 Facilitator, Albany County School District Teen Parent Program (Laramie, WY)

1997-Present Owner/Therapist, Susan Markus Counseling and Consultation, P.C. (Laramie, WY)

1992-Present Adjunct Instructor, University of Wyoming Graduate Program in Counselor Education (Laramie, WY)

1989-1997 Student Affairs Professional, University of Wyoming, Counselor in TRIO Project, Coordinator of Student Success Program, Academic Advisor (Laramie, WY)

1987-1989 Child Protection Worker and Family Worker, Department of Family Services (Cheyenne, WY)

OTHER PROFESSIONAL ACTIVITIES

2003-Present System of Care Steering Committee

2001-Present American Counseling Association

1997-Present Licensed Professional Counselor

1996-Present Nationally Certified Counselor

HONORS RECEIVED

1996 University of Wyoming First-Year Program Outstanding Instructor Award

1996 Arden J. White Academic Excellence Scholarship Recipient

BIOGRAPHICAL SKETCH

Name: Peggy Nikkel	**Title:** Executive Director
Organization: UPLIFT (Wyoming's Federation of Families for Children's Mental Health)	

Institution (Name, City, State)	**Degree**	**Year**	**Field of Study**
Northeastern Oklahoma State University, Tahlequah, Oklahoma	109 hrs. towards Bachelor of Arts	Not completed	Theatre

EMPLOYMENT

1997-Present	UPLIFT, Executive Director
1990-Present	Christian Dramatist
1990-Present	Free Lance Writer
1996-1997	Substitute Teacher, Platte County School District
1995-1996	Teacher's Aid, Platte County School District

APPOINTMENTS

1999-Present	Governor's Mental Health Planning Council
2004-Present	Governor's Advisory Committee, Children & Families Initiative
2002-Present	Central Wyoming Counseling Center Board of Directors

OTHER PROFESSIONAL ACTIVITIES

2000-Present	System of Care Steering Committee
1999-Present	Mental Health Data Committee
2003-Present	Wyoming Early Childhood Summit, Chair of Social/Emotional Committee
2004-Present	National Review Work Group for Statewide Family Networks
1997-Present	Conference Presenter at state and national conferences
2004-Present	Consultant, National Technical Assistance Center for Statewide Family Networks
2004-Present	Consultant, Georgetown University Center for Child and Human Development

HONORS RECEIVED

2002	**NATIONAL FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH *CLAIMING CHILDREN AWARD***

PUBLICATIONS

P. Nikkel (in press) *Building Partnerships with Families*, in Building Early Childhood Mental Health Systems of Care. Knitzer, J., Kaufmann, R., & Perry, D. Eds. Baltimore: Brookes.

BIOGRAPHICAL SKETCH

Name: Elizabeth Pfisterer, RHIT	**Title:** Medicaid Waiver Specialist
Organization: Wyoming Department of Health, Mental Heath Division	

Institution (Name, City, State)	**Degree**	**Year**	**Field of Study**
Dakota State University Madison, S.D.	Associate of Arts	1977-1979	Records and Information Management
American Health Information Management Association	Registered Health Information Technician accreditation	1979	Health Information Management

EMPLOYMENT

2004 – Present Wyoming Department of Health, Mental Health Division, Medicaid Waiver Specialist. Developing the program and writing application for a children's mental health home and community based Medicaid waiver. Developed and implemented a stakeholder communication plan. Have met with multiple stakeholder groups from around the state to share information about waiver implementation plans. Obtained assistance to design a website and e-mail account to allow stakeholder access to waiver proposals. Participating in discussions and work surrounding the SAMHSA system of care grant application.

2003 – 2004 Wyoming Department of Health, Developmental Disabilities Division, Adult Waiver Specialist. Reviewed and approved client plans of care funded by Medicaid Home and Community Based waiver funds. Participated in on-site agency surveys. Researched and developed provider education packages on topics to include client confidentiality and guardianship. (Cheyenne, WY)

1984 – 2003 Wyoming State Training School, Records Manager. Managed long-term care records system, including computerization and management of medical and habilitation sections. Developed and implemented staff education programs specific to levels of staff involvement. Developed and maintained written procedure manuals for all record system components and implemented staff reference manual for system use. (Lander, WY)

1980 – 1984 Madison Clinic, LTD., Medical Transcriptionist/Records Technician for private practice physician clinic. Performed all activities of clinic records department for seven physician clinic. (Madison, SD)

1979 Kossuth County Hospital, Accredited Records Technician/Medical Records Department Manager. Managed records system maintenance activities for small acute care county hospital. (Algona, IA)

OTHER PROFESSIONAL ACTIVITIES

April 2005	Presentation on Records Documentation for Wyoming Department of Health Aging Division's Long Term Care Waiver conference
2004-Present	System of Care Steering Committee
Sept. 2004	Presentation on Nursing Documentation systems for Wyoming Certified Developmental Disabilities Nursing Conference
April 2004	Presentation on Records Documentation for Wyoming Department of Health Aging Division's Community Based In-Home Services Access conference
June 2003	Presentation on Client Confidentiality for Fremont County Emergency Medical Technicians
June 2002	Presentation on Client Confidentiality for Fremont County Emergency Medical Technicians
1980-Present	Certification maintenance completing 20 hours of continuing education hours for every 2 year certification cycle
1979-Present	American Health Information Management Association certification

HONORS RECEIVED

March 1997 Award of Excellence from Wyoming State Archives

BIOGRAPHICAL SKETCH

NAME: Dennis F. Mohatt	TITLE: Senior Program Director
ORGANIZATION:	WICHE Mental Health Program

EDUCATION

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
University of Oregon, Eugene, OR	B.S.	1981	Psychology
Mansfield University, Mansfield, PA	M.A.	1984	Community-Clinical Psychology

EMPLOYMENT

2001-pres Senior Program Director, Western Interstate Commission for Higher Education (WICHE) Mental Health Program, Boulder, CO.
2000-01 Vice President of Development, ABSolute Integrated Solutions, FHC Health System, Inc., Norfolk, VA.
1999-00 Western Regional Vice President for Program Development, Alternative Behavioral Services, FHC Health System, Inc., Norfolk, VA.
1996 Medicaid Managed Care Director, Dept of Social Services, State of Nebraska, Lincoln, NE.
1995-96 Executive Director, Child Guidance Center, Lincoln, NE.
1994-97 Senior Consultant, Frontier Mental Health Services Resource Network, Dept of Psychology, University of Denver, Denver, CO.
1994-98 Member, National Advisory Committee on Rural Health, U.S. Dept of Health and Human Services, Washington, D.C.
1989-95 Executive Director, Menominee County CMHC, Menominee, MI.

Dennis F. Mohatt, M.A. is the director of the WICHE Mental Health Program. He has 20 years of experience and training in rural community mental health. Mr. Mohatt was trained via a NIMH Training Fellowship in rural mental health, receiving his Master's in rural community-clinical psychology from Mansfield University in Pennsylvania in 1984. As the executive director of the Menominee County CMHC, in Michigan's Upper Peninsula, Mohatt was responsible for the planning, operation, and evaluation of a successful rural ACT program. During his tenure as the Deputy Director of HHS for Nebraska, where he served as the state's commissioner of mental health, he provided the leadership for the establishment of ACT and Medicaid coverage for ACT services in this rural state. Most recently, Mohatt served as the chief consultant to the rural issues subcommittee of the President's New Freedom Commission on Mental Health.

HONORS

2000 Young Alumni Award, Mansfield University Alumni Assn, Society of Honor.
1997 Victor I. Howery Award, National Assn for Rural Mental Health.
1995 Distinguished Service Award, National Assn for Rural Mental Health.

SELECTED PUBLICATIONS & PRESENTATIONS

Mohatt, D. (2001). Culturally competent care: The rural context. In *Reducing disparities: Ethnic minorities and mental health*. (Atlanta: The Carter Center).

Mohatt, D. (2000). Access to Mental Health Services in Frontier America. *Washington Academy of Sciences 86*(3), 35-47.

Holzer, C.E., III, Mohatt, D.F., Goldsmith, H.F., & Ciarlo, J. (1998). The availability of health and mental health providers by urban-rural county type. In: *Mental Health, United States, 1998*. (Rockville, MD: U.S. Dept of Health and Human Services).

Mohatt, D. (1997). Access and availability of mental health services in frontier America. *Letter to the Field, No. 4*. (Denver, CO: University of Denver, Frontier Mental Health Services Resource Network.

Mohatt, D. (1996). Rural issues in public sector managed behavioral health care. In Minkoff, K. & Pollack, D. (Eds.) *Managed Mental Healthcare in the Public Sector: A Survival Manual*. (New York: Harwood Academic).

Ciarlo, J.A., Wackwitz, J.H., Wagenfeld, M.O., & Mohatt, D.F. (1996). Focusing on "Frontier": Isolated rural America. *Letter to the Field, No. 2*. (Denver, CO: University of Denver, Frontier Mental Health Services Resource Network).

Mohatt D., & Kirwan, D. (1995). *Model Programs in Rural Mental Health*. (Washington, DC: U.S. Office of Rural Health Policy, DHHS, HRSA, USPHS).

Wagenfeld, M., Murray, D., Mohatt, D., & DeBruyn, J. (1994). *Mental Health and Rural America: An Overview and Annotated Bibliography (Volume II)*. (Washington, DC: U.S. Government Printing Office).

Mohatt, D. (1994). *Community Aspects of Health Care Reform and Rural Mental Health: Proceedings of the Conference: Implementing Health Care Reform in Rural America*. (Iowa City: University of Iowa Press.

Larson, M.L., Beeson, P.G., & Mohatt, D. (1994). *Taking Rural Into Account: Report on the Center for Mental Health Services National Public Forum, Lincoln, Nebraska, June 24, 1993*. (Rockville, MD: U.S. Dept of Health & Human Services, Center for Mental Health Services).

Mohatt, D.F., & Beeson, P.G. (1993). *Healthcare Reform and Rural Mental Health*. (Wood River, IL: National Association for Rural Mental Health).

An overview of rural mental health issues: Challenges and opportunities caring for the country. AHRQ Regional User Liaison Program Conference, June 2002, Denver, CO

BIOGRAPHICAL OUTLINE FORM

NAME: Chuck McGee	TITLE: Project Director, Program Evaluation
ORGANIZATION:	WICHE Mental Health Program

EDUCATION

INSTITUTION (Name, City, State)	DEGREE	YEAR	FIELD OF STUDY
University of Southern Colorado, Pueblo, CO	B.A.	1970	Philosophy, Mathematics
University of Colorado, Boulder, CO	M.A.	1980	Psychology, Program Evaluation

EMPLOYMENT

1997-pres	Project Director, Program Evaluation, Western Interstate Commission for Higher Education (WICHE) Mental Health Program, Boulder, CO.
1995-1997	Program Planning & Evaluation Specialist II, Missouri Dept of Mental Health, Div of Comprehensive Psychiatric Services, Jefferson City, MO.
1994	Research Analyst IV, Missouri Dept of Mental Health, Jefferson City, MO
1992-1993	Special Assignment: CTRAC Project Manager for Users, User Representative for Missouri Dept of Mental Health, Div of Comprehensive Psychiatric Services, Jefferson City, MO.
1990-1993	Program Planning & Evaluation Specialist I, Missouri Dept of Mental Health, Div of Comprehensive Psychiatric Services, Jefferson City, MO.
1989	Child & Adolescent Service System Project, Missouri Dept of Mental Health, Div of Comprehensive Psychiatric Services, Jefferson City, MO.
1987-1988	Program Evaluator, Missouri Dept of Mental Health, Div of Comprehensive Mental Health Services, Jefferson City, MO.
1986	Child/Adolescent Planner, Colorado Div of Mental Health, Ft. Logan, CO.
1982-1985	Human Service Planner, City of Pueblo, Colorado, Div of Health and Human Services.

Chuck McGee, M.A., will be the project data manager. Chuck leads the Western States Decision Support Group (WSDSG), a regional division of the federal Mental Health Statistics Improvement Program (MHSIP). He has researched, presented, and reported on state needs and prevalence assessments, co-directed the development of culturally competent queries for the MHSIP Consumer Report Card, and collaborated with state mental health authorities on monitoring the downsizing of state hospitals.

SELECTED PUBLICATIONS & PRESENTATIONS

McGee, C. (2002, May). *Benefits of Using Prevalence Data in Penetration Rates.* Presentation at the National Conference on Mental Health Statistics. (Washington, D.C.).

McGee, C. (2002, January). *Population in Need of Mental Health Services and Public Agencies' Service Use in Colorado*. Prepared for Colorado Mental Health Services, funded by the Colorado Legislature. (WICHE: Boulder, CO).

McGee, C. (2002, January). *Prevalence, Service Utilization, and Penetration*. Presentation at the Midwest User Group Meeting of the Mental Health Statistics Improvement Program. (Chicago, IL).

McGee, C., & Press, A. (2001, Oct.). *Nebraska MHSIP: Prevalence, Utilization and Penetration*. Prepared for the Nebraska Div. of Mental Health, Substance Abuse and Addiction Services, funded through the Mental Health Statistics Improvement Program, of the U.S. SAMHSA Center for Mental Health Services. (WICHE: Boulder, CO).

McGee, C. (2001, June). *Assessing Cultural Competence in Psychiatric Training: Year 1 Evaluation Report*. SAMHSA CAG grant, Boston University Div of Psychiatry. (WICHE: Boulder, CO).

McGee, C., Nikkel, P., Nees, D., & Smith, M. (2001, May). *Partnership in the Wyoming MHSIP Surveys*. Presentation at the National Conference on Mental Health Statistics for the Western States Decision Support Group. (Washington, D.C.).

McGee, C. & Press, A. (1999, June). *Needs Assessment in the West: Report on a Workshop and Subsequent Analysis*. Paper presented at the National Conference on Mental Health Statistics for the Western States Decision Support Group. (Washington, D.C.).

Evans, C., McGee C. (1998). Collaboration Between a State Alliance for the Mentally Ill and a State Mental Health Authority in Monitoring the Consequences of Downsizing. *The Journal of Behavioral Health Services and Research 25* (1), 43-50.

McGee, C. (1996, July). Missouri's Mental Health Performance Measurement. State Reform Grant Application for the State of Missouri.

McGee, C. Mental Health Statistic Improvement Program (MHSIP), Application for Continued Grant. Several years ending with FY96 request.

McGee, Evans, & Roos. (1992, Oct.). *A Comparison of Behavior Problems of Children at Admission to Various Programs*. Presentation at the Regional Conference of the Mental Health Statistics Improvement Program.

McGee, C. (1990). Comprehensive Service System for Children and Youth. Missouri's Comprehensive Mental Health Plan Update.

McGee, C., Martinez, T. D., & Meyers, S. (1984). Community Wide Needs Assessment for Human Services. (Pueblo, CO: Pueblo Area Council of Governments

BIOGRAPHICAL SKETCH

NAME Scott J. Adams, Psy.D.	**POSITION TITLE** **Senior Research Associate**
ORGANIZATION	**WICHE Mental Health**

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR(s)	FIELD OF STUDY
Michigan State University, East Lansing, MI	B.S.	1993	Psychology
Indiana State University, Terre Haute, IN	M.S.	1999	Clinical Psychology
Indiana State University, Terre Haute, IN	Psy.D.	2002	Clinical Psychology
University of Colorado Health Sciences Center, Denver, CO	Postdoctoral Fellow	10/1/02 – 9/30/03	Administration and Evaluation Psychology

EMPLOYMENT

2003 – Present	Senior Research Associate, Western Interstate Commission for Higher Education (WICHE) Mental Health Program
2002 – 2003	Postdoctoral Fellow through the University of Colorado Health Sciences Center, at the Western Interstate Commission for Higher Education (WICHE) Mental Health Program
2001 – 2002	Pre-Doctoral Intern at the Denver Veteran's Administration Medical Center
2000 – 2001	Emergency Services, Good Samaritan Hospital, Psychiatric Ward
1999 – 2000	Therapist and Psychological Assessor, The Samaritan Center
1997 – 2000	Graduate Clinician, Indiana State University Psychology Clinic
1997 – 2000	Teaching Fellow, Indiana State University

PROFESSIONAL PRESENTATIONS:

September, 2004	"The President's *New Freedom Commission, Subcommittee on Rural Issues Report*." First Annual Mental Health Conference, Larned State Hospital, Larned, Kansas.
June, 2004	"What's Up in the WICHE West: An Overview of Current Activities of the WICHE Mental Health Program," Annual Conference of the National Association of Rural Mental Health.
May, 2003	"Special Issues in Serving Rural Children and Families," Annual Conference of the Organization for Program Evaluators in Colorado.
May, 2003	"Evaluating Assertive Community Treatment in a Managed Care Setting– Methods, Outcomes, and Implications for Rural Programs," Annual Conference of the Organization for Program Evaluators in Colorado.
April, 1999	"The Reality Beliefs Inventory (RBI): Developing a Measurement of the Influence of Core Reality Beliefs on Personality Development and Alteration," Annual Meeting of the Midwestern Psychological Association.
October, 1998	"Core Beliefs, Cognitive Self-Regulation, and Personality," Annual Meeting of the Indiana Academy of Science.
October, 1998	"Personality as a Function of Core Beliefs," Annual Meeting of the Indiana Academy of the Social Sciences.

October, 1997 "Personality and Reality," Annual Meeting of the Indiana Academy of Science.

RESEARCH, REPORTS, AND PUBLICATIONS

Adams, S.J. (2002). The relationship between reality beliefs, personality traits, need for cognition, and social desirability. Unpublished Dissertation. Indiana State University.

Adams, S.J. (2004). Evaluation of Current Treatment Programs for Persons with Co-Occurring Mental Health and Substance Abuse Disorders and Agency Readiness for Change in South Dakota: Final Report. Report from the WICHE Mental Health Program for the South Dakota Division of Mental Health.

Adams, S.J. & Mohatt, D.F. (2004). Rural Mental Health in the WICHE West: Meeting Workforce Demands through Regional Partnership. Prepared by the WICHE Mental Health Program supported by an educational grant from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services.

Adams, S.J. & Mohatt, D.F. (2004). The Behavioral Health Workforce in Alaska: A Status Report. Prepared by the WICHE Mental Health Program For: University of Alaska, Statewide Office of the Associate Vice President for Health.

Adams, S.J. & Mohatt, D.F. (2003). *The Future of Wyoming's Children*: *Search Conference*. Sponsored by the Wyoming Mental Health Division. Cheyenne, Wyoming.

Adams, S.J. & Mohatt, D.F. (2003). *The Future of Wyoming's Children*: *Regional Meetings*. Sponsored by the Wyoming Mental Health Division. Rock Springs, Lander, Sheridan, and Cheyenne, Wyoming.

Adams, S.J., Mohatt, D.F., & McGee, C. (2003). South Dakota Children's Mental Health Task Force: Final Report. South Dakota Department of Human Services, Division of Mental Health. Prepared by the WICHE Mental Health Program supported by an educational grant from Eli Lilly and Company.

Adams, S.J., Mohatt, D.F., & Markus, S. (2004). Children & Families System of Care: Community Readiness for Change, Final Report. Prepared by the WICHE Mental Health Program for the Wyoming Mental Health Division.

Mohatt, D.F., McGee, C., **Adams, S.J.**, Press, A., & Holzer, C. (2002). Assessment of Need for Behavioral Health Services. Southwest Counseling Center: Rock Springs, Wyoming.

Mohatt, D.F., **Adams, S.J.,** & Bradley, M.M. (in preparation). Rural Mental Health: Opportunities and Challenges Caring for the Country. In: *Universal healthcare: Readings for the mental health professional.* Cummings, N. & O'Donohue, W. (Eds.).

Mohatt, D.F., Bradley, M.M., **Adams, S.J.**, & Morris, C.D. (in preparation). Mental Health and Rural America: 1994 – 2004, An Overview and Annotated Bibliography. Rockville, Md. Office of Rural Health Policy, HRSA, and Office of Rural Mental Health Research, NIMH, NIH.

BIOGRAPHICAL SKETCH

NAME **Mimi Bradley, Psy.D.**	POSITION TITLE **Postdoctoral Fellow**

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
University of Illinois, Urbana-Champaign, IL	B.S.	1995	Psychology
California School of Professional Psychology, San Francisco, CA	M.S.	2001	Clinical Psychology
California School of Professional Psychology, San Francisco, CA	Psy.D.	2004	Clinical Psychology
University of Colorado Health Sciences Center, Denver, CO	Postdoctoral Fellow	10/01/04 – 9/30/05	Administration and Evaluation Psychology

A. Positions and Honors.

Current	Postdoctoral Fellow, University of Colorado Health Sciences Center, at the Western Interstate Commission for Higher Education (WICHE) Mental Health Program
2003 – 2004	Pre-Doctoral Intern at the University of Colorado Health Sciences Center
2002 – 2003	Adjunct Faculty; National University, San Jose, CA
2001 – 2003	Clinical Practicum; Xanthos, Inc., Alameda, CA
2002 – 2002	Personal Development Instructor; Alvin Ailey Summer Camp, Berkeley, CA
2000 – 2001	Clinical Practicum; Federal Corrections Institute, Dublin, CA
1999 – 2000	Clinical Practicum; Bay Area Women Against Rape, Oakland, CA

RESEARCH, REPORTS, AND PUBLICATIONS

Mohatt, D.F., Adams, S.J., & **Bradley, M.M.** (in preparation). Rural Mental Health: Opportunities and Challenges Caring for the Country. In: *Universal healthcare: Readings for the mental health professional.* Cummings, N. & O'Donohue, W. (Eds.).

Mohatt, D.F., **Bradley, M.M.,** Adams, S.J., & Morris, C.D. (in preparation). Mental Health and Rural America: 1994 – 2004, An Overview and Annotated Bibliography. Rockville, Md. Office of Rural Health Policy, HRSA, and Office of Rural Mental Health Research, NIMH, NIH.

Job Description

Title of Position: Principle Investigator

Duties and Responsibilities: Provides fiscal and administrative oversight of the grant and is accountable to the pilot sites for the proper conduct of the grant. She may choose to be responsible for or appoint someone to act as a liaison with State officials and agencies.

Qualifications/Experience required for Position: Knowledge of applicable state and federal laws, rules, and regulations; human service programs; clients being served; program administration procedures; grant development and administration; technical knowledge of assigned programs. Ability to work effectively and efficiently with other staff and community organizations; identify dysfunctional relationships and environmental conditions; exercise sound judgment in the performance of assigned responsibilities; write meaningful, concise, and accurate reports and correspondence; analyze data and information and draw conclusions; train and advise program staff and service providers; assess program effectiveness.

Supervisory Relationships: May supervise subordinate staff to ensure that the objectives of the work unit are met. Interviews and selects staff. Provides training and work direction. Approves leave requests. Addresses staff problems and recommends disciplinary action. Conducts performance appraisals and completes performance documents.

Skills and Knowledge Required: Knowledge of public mental health system policies, practices and services in Wyoming, understanding of interactions between the public mental health system and criminal justice system, understanding of program design, service and stakeholder linkage processes, understanding of data analysis and supervisory/project management skills.

Personal Qualities: Well-organized, able to communicate effectively with diverse stakeholders, ability to organize and present complex systems and data information for non-systems and data oriented audiences, and ability to prioritize and multi-task.

Amount of Travel – Special Conditions or Requirements: Periodic local and interstate travel. No special conditions or requirements.

Salary Range: $48,000 based on full-time status.

Hours per Day or Week: Half time

Job Description

Title of Position: Project Director

Duties and Responsibilities: Responsible for the day-to-day oversight and implementation of the project including, but not limited to, developing a comprehensive strategic plan for the proposed SOC; establishing the organizational structure; hiring staff; and providing leadership.

Qualifications/Experience required for Position: Experience in mental health and other child and family services and programs, project management, and program evaluation. Experience with the public mental health system and its interaction with multiple, state-wide systems. Experience with the issues surrounding youth with SED who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Reports to the Principle Investigator and System of Care Steering Committee.

Skills and Knowledge Required: Knowledge of public mental health system policies, practices and services in Wyoming, understanding of interactions between the public mental health system and criminal justice system, understanding of program design, service and stakeholder linkage processes, understanding of data analysis and supervisory/project management skills.

Personal Qualities: Well-organized, able to communicate effectively with diverse stakeholders, ability to organize and present complex systems and data information for non-systems and data oriented audiences, and ability to prioritize and multi-task.

Amount of travel and any other special conditions: Periodic local and, potentially, inter-state travel. No special conditions or requirements

Salary range: $50,000 year based on full time status.

Hours per day or week: Half time.

Job Description

Title of Position: Clinical Director

Duties and Responsibilities: Responsibility for ensuring that children with SED and their families receive timely assessments and comprehensive treatment plans. The selection and oversight of implementation of training for all evidence based practice models utilized in the project will be supervised by this person.

Qualifications/Experience required for Position: Experience in mental health services and programs, project management, and program evaluation. Experience with the public mental health system and its interaction with multiple, state-wide systems. Experience with the issues surrounding youth with SED who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Reports to Principle Investigator and System of Care Steering Committee.

Skills and Knowledge Required: Knowledge of public mental health system policies, practices and services in Wyoming, understanding of interactions between the public mental health system

and criminal justice system, understanding of program design, service and stakeholder linkage processes, understanding of data analysis and supervisory/project management skills.

Personal Qualities: Well-organized, able to communicate effectively with diverse stakeholders, ability to organize and present complex systems and data information for non-systems and data oriented audiences, and ability to prioritize and multi-task.

Amount of travel and any other special conditions: Periodic local and, potentially, inter-state travel. No special conditions or requirements

Salary range: $50,000 year based on full time status.

Hours per day or week: Full time.

Job Description

Title of Position: Lead Family Contact

Duties and Responsibilities: Will participate in all aspects of implementation of the SOC and provide support services for families receiving services throughout the grant. She will also maintain the primary responsibility for working closely with families and conducting outreach efforts.

Qualifications/Experience required for Position: Experience in family organizations and working with mental health services and programs, project management, and program evaluation. Experience with public mental health system and its interaction with multiple, state-wide systems. Experience with the issues for youth with SED who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Principle Investigator and System of Care Steering Committee.

Skills and Knowledge Required: Knowledge of family organizations, public mental health system policies, practices and services in Wyoming, understanding of interactions between the public mental health system and criminal justice system, understanding of program design, service and stakeholder linkage processes.

Personal Qualities: Well-organized, able to communicate effectively with diverse stakeholders, ability to organize and present complex systems and data information for non-systems and data oriented audiences, and ability to prioritize and multi-task.

Amount of travel and any other special conditions: Periodic local and, potentially, inter-state travel. No special conditions or requirements

Salary range: $52,000 year based on full time status.

Hours per day or week: Full time.

Job Description

Title of Position: Youth Coordinator
Duties and Responsibilities: Responsible for developing programs for young people to facilitate their involvement in development of the SOC. Will assume primary responsibility for developing and managing a youth organization, and other activities that will bring the voice of youth who have SED to the project.

Qualifications/Experience required for Position: Experience in mental health services and programs, project management, and program evaluation. Some experience with the public mental health system and its interaction with multiple, state-wide systems. Experience with the issues surrounding youth with SED who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Reports to Lead Family Contact and Principle Investigator.

Skills and Knowledge Required: Knowledge of public mental health system policies, practices and services in Wyoming, understanding of interactions between the public mental health system and criminal justice system, understanding of program design, service and stakeholder linkage processes, understanding of data analysis and supervisory/project management skills.

Personal Qualities: Well-organized, able to communicate effectively with diverse stakeholders, ability to organize and present complex systems and data information for non-systems and data oriented audiences, and ability to prioritize and multi-task.

Amount of travel and any other special conditions: Periodic local and, potentially, inter-state travel. No special conditions or requirements

Salary range: $14,400/year based on full time status.

Hours per day or week: 13 hours per week.

Job Description

Title of Position: Technical Assistance Coordinator
Duties and Responsibilities: The central point person for strategizing and assessing the TA needs of stakeholders and linking these needs with ongoing TA. She may create new opportunities for training to meet ongoing changes in the community. She will coordinate TA in areas such as culturally competent practices and services, leadership, partnership/ collaboration, strategic planning, wraparound planning, sustainability, family involvement, and youth involvement. She is the link to the national Technical Assistance Partnership.

Qualifications/Experience required for Position: Experience in mental health services and programs, project management, and program evaluation. Experience with the public mental health system and its interaction with multiple, state-wide systems. Experience with the issues

surrounding youth with SED who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Reports to the Principle Investigator, Project Director, and System of Care Steering Committee.

Skills and Knowledge Required: Knowledge of public mental health system policies, practices and services in Wyoming, understanding of interactions between the public mental health system and criminal justice system, understanding of program design, service and stakeholder linkage processes, understanding of data analysis and supervisory/project management skills.

Personal Qualities: Well-organized, able to communicate effectively with diverse stakeholders, ability to organize and present complex systems and data information for non-systems and data oriented audiences, and ability to prioritize and multi-task.

Amount of travel and any other special conditions: Periodic local and, potentially, inter-state travel. No special conditions or requirements

Salary range: $38,000/year based on full time status.

Hours per day or week: Half time.

Job Description

Title of Position: Social Marketing Communications Manager
Duties and Responsibilities: Responsible for developing a social marketing/communications strategy including: a strategic plan, public education activities, and overall outreach efforts. She will also coordinate activities with the national communications campaign. The social marketing strategy will be developed to engage individuals that currently are not accessing mental health services (e.g., Native Americans and people in rural and remote areas). The business community will be engaged as part of the economic development plan for the target areas.

Qualifications/Experience required for Position: Experience in mental health services and programs, project management, and program evaluation. Experience with the public mental health system and its interaction with multiple, state-wide systems. Experience with the issues surrounding youth with SED who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system. Cultural competence expertise.

Supervisory Relationships: Reports to the Principle Investigator, Project Director, and System of Care Steering Committee.

Skills and Knowledge Required: Knowledge of social marketing techniques, especially as related to public mental health system policies, practices and services in Wyoming, understanding of interactions between the public mental health system and criminal justice system, understanding of program design, service and stakeholder linkage processes, understanding of data analysis and supervisory/project management skills.

Personal Qualities: Well-organized, able to communicate effectively with diverse stakeholders, ability to organize and present complex systems and data information for non-systems and data oriented audiences, and ability to prioritize and multi-task.

Amount of travel and any other special conditions: Periodic local and, potentially, inter-state travel. No special conditions or requirements

Salary range: $40,000/year based on full time status.

Hours per day or week: Half time.

Job Description

Title of Position: State-Local Agency Liaison

Duties and Responsibilities: Will work collaboratively with Regional Coordinators to establish interagency involvement in the project's structure and process by developing and/or changing interagency agreements and other public policies relevant to the creation of the SOC.

Qualifications/Experience required for Position: Experience in mental health and substance abuse services and programs, project management, and program evaluation. Experience with the public mental health system and its interaction with multiple, state-wide systems. Experience with the issues surrounding youth with SED who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Reports to Principle Investigator, Project Director, and System of Care Steering Committee.

Skills and Knowledge Required: Knowledge of public mental health system policies, practices and services in Wyoming, understanding of interactions between the public mental health system and criminal justice system, understanding of program design, service and stakeholder linkage processes, understanding of data analysis and supervisory/project management skills.

Personal Qualities: Well-organized, able to communicate effectively with diverse stakeholders, ability to organize and present complex systems and data information for non-systems and data oriented audiences, and ability to prioritize and multi-task.

Amount of travel and any other special conditions: Periodic local and, potentially, inter-state travel. No special conditions or requirements

Salary range: $50,000-$100,000/year based on full time status.

Hours per day or week: 4 hours per week.

Job Description

Title of Position: Regional Coordinator

Duties and Responsibilities: Will serve as local fiduciary of funding for services with the goal of creating wraparound services via blended funds that meet the needs of the child and family; will establish needed interagency involvement in the project's structure and process to create a system of care that is responsive to community needs; will ensure that evidence-based practices are developed and implemented, that services provided are culturally and linguistically competent, and will establish performance standards that are monitored through a management information system. State-local agency liaisons will work in collaboration with this position.

Qualifications/Experience required for Position: Experience in mental health and substance abuse services and programs, project management, and program evaluation. Experience with the public mental health system and its interaction with multiple, state-wide systems. Experience with the issues surrounding youth with SED who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Reports to LCC and Clinical Director.

Skills and Knowledge Required: Knowledge of public mental health system policies, practices and services in Wyoming, understanding of interactions between the public mental health system and criminal justice system, understanding of program design, service and stakeholder linkage processes, understanding of data analysis and supervisory/project management skills.

Personal Qualities: Well-organized, ability to meet deadlines and plan ahead to avert crises. Ability to communicate effectively with diverse stakeholders.

Amount of Travel – Special Conditions or Requirements: Some inter-state travel anticipated as part of this project. No special conditions or requirements.

Salary Range: $38,000 based on full-time status.

Hours per Day or Week: Full time.

Job Description

Title of Position: Regional Care Manager

Duties and Responsibilities: Will work with families to identify and select a Family Care Coordinator; will partner with local Department of Family Services staff, Juvenile Probation, schools, health care providers and UPLIFT to develop a strategy for identifying and admitting youth at risk of residential placements; facilitate family outreach, advocacy, and evaluation assistance; monitor confidentiality practices and adequate consent procedures; educate communities and service partners of the mission, values, goals, and population served by the system of care in their region; work with Family Care Teams to monitor the care and services

provided by service providers in their region to include: utilization of services, progress toward individualized treatment goals, re-determination of strengths, priorities, and resources, and update of the treatment plan as often as necessary; will handle grievance proceedings.

Qualifications/Experience required for Position: Experience in mental health and substance abuse services and programs, project management, and program evaluation. Experience with the public mental health system and its interaction with multiple, state-wide systems. Experience with the issues surrounding youth with SED who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Supervised by Project Coordinator, supervises post-doctoral fellow.

Skills and Knowledge Required: Knowledge of SED and public mental health. Supervision and management skills.

Personal Qualities: Ability to work well with a diverse group of stakeholders and project staff. Ability to communicate effectively, problem solve and program development and implementation issues.

Amount of Travel – Special Conditions or Requirements: Some inter-state travel anticipated as part of this project. No special conditions or requirements.

Salary Range: $40,000/year

Hours per Day or Week: Full time.

Job Description

Title of Position: Family Care Coordinator

Duties and Responsibilities: Will advocate on behalf of child/family with the service system; complete identified strengths based assessments with full participation of child/family/caretaker to determine community-based services needed to ensure health and safety in the home and community; facilitate development of multi-service community-based plan that facilitates access to clinical and non-clinical services and information, community resources, and relationships; collaborate with case managers from other service agencies; locate, arrange and refer to direct services; monitor service plan, providers, and identified outcomes (at least quarterly) to review identified goals, re-determine strengths and priorities, and resources and update the plan as needed; monitor child and family satisfaction of services and establish an open forum for the expression of concerns and disagreements and act as child/family first contact for complaint/grievance process; coordinate transition and referrals moving from one setting to another; complete case records; maintain required training competencies to include: Family Partnership Wraparound model, Individuals with Disabilities Education Act, Wyoming Special Education Rules and Regulations, effective advocacy, children's mental health disorders, knowledge of regional services, Multi-system Therapy or Functional Family Therapy,

therapeutic foster care, crisis services, cultural and linguistic competence and family focused care, and system of care values and principles.

Qualifications/Experience required for Position: Extensive experience in providing and coordinating multiple services for children and families.

Supervisory Relationships: Reports to LCC and Clinical Director.

Skills and Knowledge Required: Knowledge of SED and public mental health. Supervision and management skills.

Personal Qualities: Well organized with ability to multitask and communicate well between large systems of care.

Amount of Travel – Special Conditions or Requirements: No travel anticipated as part of this project. No special conditions or requirements.

Salary Range: $33,000/year based on full time salary.
Hours per Day or Week: Full time.

Section H - Confidentiality and SAMHSA Participant Protection/Human Subjects

1. Protection of Clients and Staff from Potential Risks

This section provides information regarding procedures and activities, which will guide our project to insure confidentiality and to protect clients and staff from risk. This project falls under the Mental Health Division (DMH) and involves a collaborative effort from a variety of agencies to provide a full array of mental health and support services to children who have serious emotional disturbances.

All research activities at the Wyoming Department of Health must have approval by their Investigational Review Board (IRB) prior to implementation. Specifically, all research will be conducted within the parameters of the Code of Federal Regulations and its sections 45 CFR 46 and 38 CFR 15, and, where applicable, 21 CFR 50 and 56.

To ensure that research studies at DOH are conducted in compliance with all Federal, State, and agency regulations and ethical standards regarding human research, the IRB shall review all research projects for: 1) Scientific integrity, 2) Risk/benefit analysis, 3) Safety of human subjects, 4) Ethical treatment of research participants, 5) Consent and assent document quality, 6) Justice and equity in selection of research subjects, and 7) Investigator and research staff training.

The special vulnerability of children makes consideration of involving them as research subjects particularly important. To safeguard their interests and to protect them from harm, special ethical and regulatory considerations are in place for reviewing research involving children (45 CFR Part 46, Subpart D). The IRB must consider the benefits, risks, and discomforts inherent in the proposed research and assess their justification in light of the expected benefits to the child-subject or to society as a whole. In calculating the degree of risk and benefit, the IRB should weight the circumstance of the subjects under study, the magnitude of risks they may accrue from the research procedures, and the potential benefits the research may provide to the subjects or class of subjects.

The potential risks or adverse effects (physical, medical, psychological, social, legal) to any person involved in this project are minimal and no more than those of existing, traditional mental health services provided to youth and families and from their participation in regular evaluation and quality improvement activities. The key difference with this project is in the organization and coordination of the delivery of services, following established systems of care principles and best-practice guidelines, rather than in an introduction of novel types of services to be delivered.

The risk or adverse effects of services to clients is only a minor possibility. The risks are reduced through various procedures, such as protection of confidentiality and efforts to prevent labeling clients that further stigmatize the population being served. Efforts to ensure other clients do not stigmatize each other will be considered in service delivery. The risk to staff is possible from adverse events (e.g., client assaulting staff). Appropriate law enforcement would be engaged in such circumstances. Staffs are provided training in conflict de-escalation. We do not anticipate any true physical risks for staff working on this project.

This project does not fund medical services, though many clients are actively involved in medical care. Physicians and other medical personnel will be consulted to assure appropriate medical services being available to clients. The presence of medical interventions for clients does not pose any foreseeable risks to staff.

There is the possibility of psychological risk given the stigma and shame often associated with having a child with mental illness. There would seem less risk with coordinated, community-based care than with more traditional mental health services. Stigma may provide additional barriers to receiving care that is the focus on care coordination activities. Every effort will be made to address the psychological needs of families in services. The risk to staff is minimal, and open dialogue with staff on psychological burden of care giving will be conducted. Stigma could be felt by social features (such as peer pressure) that further stigmatize families or workers. Part of the effort of the project through its communications management will address stigma reduction. Legal risk seems greater for non-participation than participation in the project. A purpose of the project is to reduce the reliance on institutional care, such as juvenile incarceration or other legal-based out of home care. The success of the project reduces legal risk.

Evaluation activities will follow up on material covered by services and not pose particular risks. Families who share common experiences will be employed by the project to help with the evaluation activities to further protect families from risk. Families employed will be trained in methodology, confidentiality, and ethical issues related to service evaluation.

2. Fair Selection of Participants

The target population limits those eligible for service from the project. It includes children with severe emotional disturbances who are at risk and have multiple problems. This general definition of the target population includes many more children than are currently being served, and will be served by funds from this project. It is assumed that community support for reform activities will enhance wider participation, and more children will be seen. However, eligible children will be seen without discrimination until capacity is reached. Some children then will not participate in funded activities, but will be appropriately referred to existing services.

The target population was selected by a community collaborative process and was intended to target those at greatest risk. This project poses to address their concerns as a priority. There are considerably more children out of service delivery networks now, and this project will reduce the numbers through multiple financing mechanisms.

3. Absence of Coercion

Participation of the targeted client population in this project is voluntary unless court ordered. Then participants are provided options as well, though participation may be the least-restrictive option. Participants are not paid for participation in services (nor evaluations), though minor funds for incentives for responding to evaluations may be provided. The incentives would not be enough to coerce participation. Staff will explain the benefits of participation to families, but not coerce participation.

Clients may receive services, even if they do not complete the services recommended. Clients are free to discontinue services without penalty from the service providers (unless the courts impose outside sanctions for discontinuance.)

4. Data Collection

Data will be collected in various ways for program monitoring and evaluation. Staff will collect data as services continue. Some families will be recruited, trained, and employed to facilitate data collection, especially for clients who discontinue services for follow-up evaluations. Project staff, consultants, and families will collect data following standard procedures for data collection. Data may be collected from face-to-face interviews, home visits, case records, or phone contacts.

Data will be kept for a reasonable (legal) time to assure responsibilities for accounting are provided. However, data will be destroyed when reports are filed and storage no longer required.

5. Privacy and Confidentiality

Client confidentiality during all the processes of the project, including and with data collection, will be protected. Client identification numbers are assigned to protect confidentiality. Intersystem data sharing will use these unique client identification numbers for evaluation and monitoring reporting. All data collectors maintain locked files with restricted access on computers with password protection. Staff members have had opportunities for training in HIPPA requirements and these will be continued for all staff coming on through this project.

6. Adequate Consent Procedures

Project participants will be provided written descriptions of the project. This will include not only a description of services but also a discussion of the purpose of their participation. Clients are provided standard forms for written consent after they have been given a full description of the project. Only those with legal authority (parents; guardians) may sign for children. Consent includes basics such as: voluntary participation; right to withdraw from project without penalty; potential risks; and plans to protect from risk.

Some participants may have difficulty with written informed consent for various reasons: they may be disabled, have difficulties with mobility, may have literacy problems, or may have visual limitations. Some clients may require consent processes in languages other than in English. Bilingual staff and/or other state means to secure language assistance will be utilized as necessary. Persons with a need will have all consent-related material and questions for monitoring/evaluation presented orally if preferred. Persons requiring more time for reading through materials or other assistance will have this provided. When questions arise as to the person’s comprehension of materials, discussions of the questions will help assure informed consent. The project assumes responsibility for assurances that informed consent is achieved, despite circumstances that pose barriers.

If participants are being surveyed for purposes of monitoring/evaluation of the project, a separate consent form with appropriate explanation of the purpose provided. Though a minor incentive

will be provided to promote the evaluation process, no sanctions will be provided for nonparticipation.

All informed consent procedures must be approved through the IRB processes.

7. Risk/Benefit Discussion

The benefits to participation in services include improved child mental health, improved family and child functioning, improved access to services, improved chances of receiving services in the least-restrictive settings, and improved service delivery. By providing an array of needed services, clients should experience benefits to many dimensions of their family life.

The risks of participation are minimal. No physical risks are associated with coordinated, comprehensive care. The project does not provide medical benefits, though associates itself with coordination of care that improves access to medical care. Adverse effects of non-participation certainly far outweigh any potential adverse effects from participation in care. Clients may or may not participate in medical care, though the care coordination approach emphasizes access to a wide array of care services.

Risk for physical, psychological, social, and legal issues were discussed earlier. Any risk is far outweighed by the benefits to participants for their involvement. Rather than being isolated and alone in facing the problems of child mental illness, this project provides a family-centered, culturally competent, community-based approach to care coordination.

Appendix 2: Governor's Assurance

Appendix 3: Data Collection Procedures and Instruments

MHSIP Consumer Survey (Version 1.1, Feb, 2000)						
In order to provide the best possible mental health services, we need to know what you think about the services you received during the last (specify timer period), the people who provided it, and the results. There is space at the end of the survey to comment on any of your answers.						
Please indicate your agreement/disagreement with each of the following statements by circling the number that best represents your opinion. If the question is about something you have not experienced, circle the number 9 to indicate that this item is "not applicable" to you.	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received here.	1	2	3	4	5	9
2. If I had other choices, I would still get services from this agency.	1	2	3	4	5	9
3. I would recommend this agency to a friend or family member.	1	2	3	4	5	9
4. The location of services was convenient (parking, public transportation, distance, etc.).	1	2	3	4	5	9
5. Staff were willing to see me as often as I felt it was necessary.	1	2	3	4	5	9
6. Staff returned my call in 24 hours.	1	2	3	4	5	9
7. Services were available at times that were good for me.	1	2	3	4	5	9
8. I was able to get all the services I thought I needed.	1	2	3	4	5	9
9. I was able to see a psychiatrist when I wanted to.	1	2	3	4	5	9
10. Staff here believe that I can grow, change and recover.	1	2	3	4	5	9
11. I felt comfortable asking questions about my treatment and medication.	1	2	3	4	5	9
12. I felt free to complain.	1	2	3	4	5	9
13. I was given information about my rights.	1	2	3	4	5	9
14. Staff encouraged me to take responsibility for how I live my life.	1	2	3	4	5	9
15. Staff told me what side effects to watch out for.	1	2	3	4	5	9
16. Staff respected my wishes	1	2	3	4	5	9

about who is and who is not to be given information about my treatment.						
17. I, not staff, decided my treatment goals.	1	2	3	4	5	9
18. Staff were sensitive to my cultural background (race, religion, language, etc.)	1	2	3	4	5	9
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	1	2	3	4	5	9
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	1	2	3	4	5	9

MHSIP Consumer Survey (Version 1.1, Feb, 2000)

In order to provide the best possible mental health services, we need to know what you think about the services you received during the last (specify timer period), the people who provided it, and the results. There is space at the end of the survey to comment on any of your answers.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
As a Direct Result of Services I received:						
21. I deal more effectively with daily problems.	1	2	3	4	5	9
22. I am better able to control my life.	1	2	3	4	5	9
23. I am better able to deal with crisis.	1	2	3	4	5	9
24. I am getting along better with my family.	1	2	3	4	5	9
25. I do better in social situations.	1	2	3	4	5	9
26. I do better in school and/or work.	1	2	3	4	5	9
27. My housing situation has improved.	1	2	3	4	5	9
28. My symptoms are not bothering me as much.	1	2	3	4	5	9

Please feel free to use this space to comment on any of your answers. Also, if there are areas which were not covered by this questionnaire which you feel should have been, please write them here. Thank you for your time and cooperation in completing this questionnaire.

Please provide the following information for statistical compilation purposes.

Male ____ Female ____ Age: ____

Ethnicity: (check one) ____ Caucasian ____ Asian ____ African-American ____ Native-American

____ Latino ____ Other (please specify) _____

Appendix 4: Sample Consent Forms

Wyoming Child Mental Health Initiative
Draft Consent Form- Parent

Program Description: The Wyoming Child Mental Health Initiative (CMHI) is a program to serve the mental health and substance abuse treatment needs of youth and families. The CMHI is run out of the Wyoming Department of Health, Mental Health Division in collaboration with child and family serving agencies in your community. You may be receiving services at one or several of these agencies. Typically, youth served by the CMHI have multiple issues and, therefore, interact with several care providers and services. This program is exploring how to best coordinate your family's care. A Care Manager will be working with your family and child to determine your family's individual needs. It is the goal of this program to provide community-based services, which decrease the need for out-of-home placements.

Procedures: If you are eligible for this program and desire to take part in it, then a variety of services and a treatment team will be available to you. An admission process will be undertaken that includes the following procedures:

1. A Care Manager will talk to you and your family about your needs, family strengths, and the services you are currently receiving. At the meeting the Care Manager will explain the CMHI program. There may need to be follow-up meetings if you are unsure about entering the program or need more information. Both the parents/guardians and the youth will need to agree to be in this program. Once agreeing to enter, a chart is started and initial service contacts are scheduled for the next few days.

2. The following information is gathered so the treatment team may best serve you.

   A. Initial Assessment and Treatment Plan: The initial assessment documents a number of things, including reason for entering the program, mental health history, physical health, use of alcohol and drugs, education and employment, social development and functioning, and so forth. Afterward an individualized treatment plan is developed in collaboration with you and your child.

   B. Treatment Plans: The information from the assessments will be used to decide on treatment goals you agree with. We will give you information about who the treatment will involve and how often we expect to meet.

Discomforts and Risks: The program has minimal risk to you and, in fact, seeks to lower risks for you and your child. The program offers 24-hour crisis care. You can access this care by calling _____. Sometimes therapy can be a difficult process, but its purpose is to help you improve your life in a manner you see fit. It is possible that risks exist that are unknown at this time, but your treatment team will try to either remove or minimize risks that arise.

Benefits: Participation in the CMHI program will have different benefits for different people, but some who enter the program may not benefit from it. The CMHI is based on the current

understanding of how to most effectively work with youth and families. We expect that we may best serve your family by better coordinating the services your child receives. Although most people get some benefit from treatment, we cannot guarantee such benefit. Also, you or your child may decide to leave the program if you find it unhelpful or no longer necessary.

Source of Funding: The CMHI is funded in part by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), a federal agency.

Cost to You: Assuming that you are eligible for funding or that there are State funds available, there is no cost to you for participating in the program.

Program Withdrawal: Taking part in this program is voluntary. You have the right to choose not to take part in this program. If you choose to take part, you have the right to stop at any time. Program staff cannot decide to stop your participation without your permission.

Confidentiality: You and your family have a right to confidentiality of your records. However, circumstances that involve likely danger to yourself or others, or in which your health is being compromised, require that clinicians act to prevent harm to you or others. In these situations, clinicians may have to break confidentiality.

AUTHORIZATION:

I have read this paper about the program or it was read to me. I understand the possible risk and benefits of this program. I know that being in this program is voluntary. I choose to be in this program. I know I can stop participating in the program. I will get a copy of this consent form. (Initial all the previous pages on the consent form).

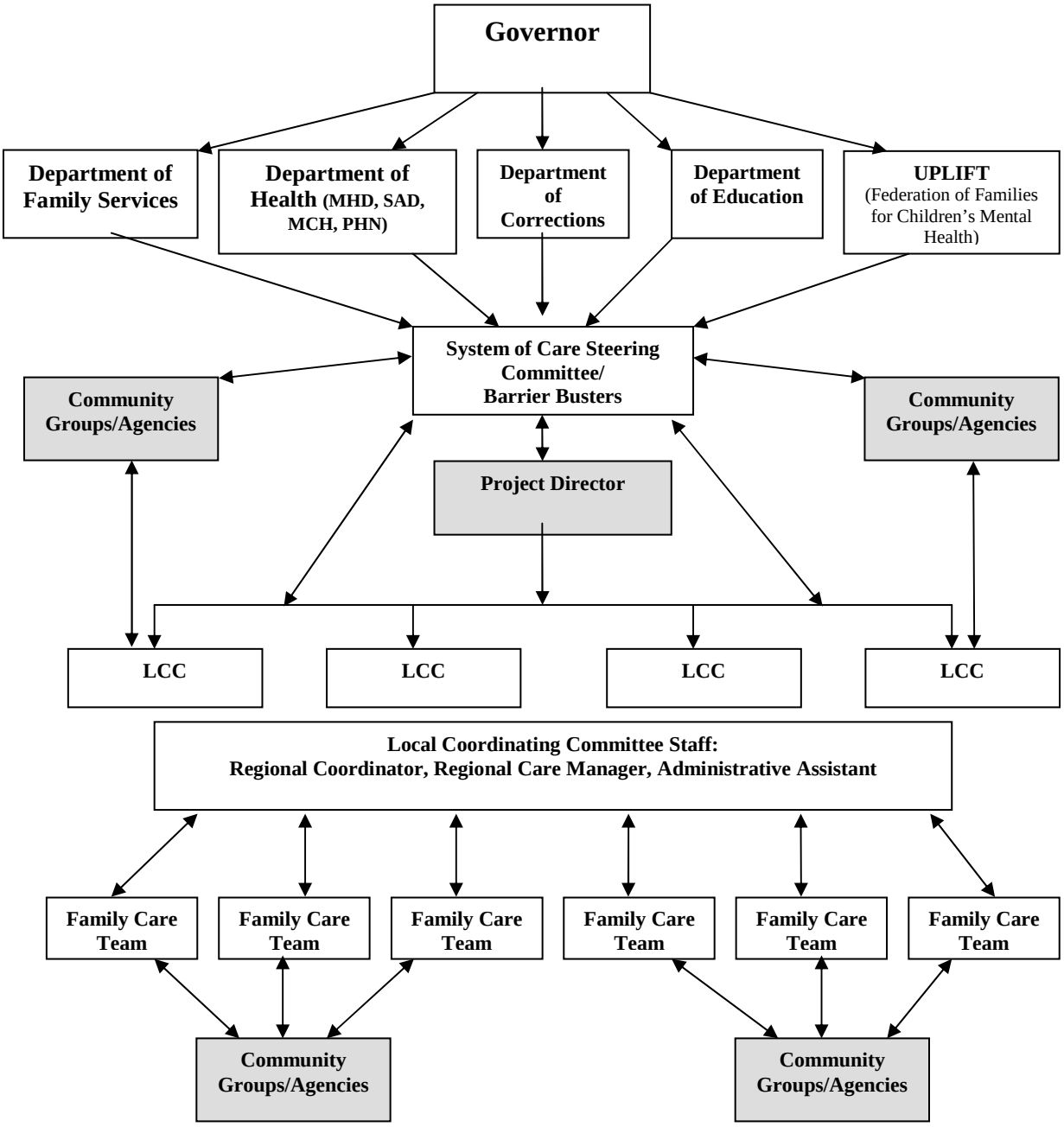
Signature:_____Print Name_____Date_____

Consent form explained by:_____Print Name_____Date_____

Investigator_____Date_____

Appendix 5: Non-Federal Match Certification

Appendix 6: Organizational Chart, Staffing Pattern, Timeline, and Management Chart.



MHD = Mental Health Division; SAD = Substance Abuse Division; MCH = Maternal and Child Health; PHN = Public Health Nursing

Staffing & Management Chart

Position	Responsibilities Related to Project Goals	% of Time
Principal Investigator: Lisa Brockman	Provides fiscal and administrative oversight of the grant and is accountable to pilot sites for the proper conduct of the grant. She may choose to be responsible for or appoint someone to act as a liaison with State officials and agencies.	.5 FTE
Project Director: Marilyn Patton	Responsible for the day-to-day oversight and implementation of the project including, but not limited to, developing a comprehensive strategic plan for the proposed SOC; establishing the organizational structure; hiring staff; and providing leadership.	1 FTE
Clinical Director: To Be Named	Responsibility for ensuring that children with SED and their families receive timely assessments and comprehensive treatment plans. The section and oversight of implementation of training for all evidence based practice models utilized in the project will be supervised by this person.	.5 FTE
Lead Family Contact: Peggy Nikkel	Will participate in all aspects of implementation of the SOC and provide support services for families receiving services throughout the grant. Will also maintain primary responsibility for working closely with families and conducting outreach efforts.	1 FTE
Youth Coordinator: To Be Named	Responsible for developing programs for young people to facilitate their involvement in development of the SOC. Will assume primary responsibility for developing and managing a youth organization, and other activities that will bring the voice of youth who have SED to the project.	.5 FTE
Key Evaluation Staff: WICHE	Will conduct evaluations of implementation of SOC activities, consumer outcomes, and other relevant indicators. Will provide training in EBP, cultural competence, wraparound, and SOC governance and financing strategies.	.5 FTE
Technical Assistance Coordinator: Susan Markus	The central point person for strategizing and assessing the TA needs of stakeholders and linking these needs with ongoing TA. She may create new opportunities for training to meet ongoing changes in the community. She will coordinate TA in areas such as culturally competent practices and services, leadership, partnership/ collaboration, strategic planning, wraparound planning, sustainability, family involvement, and youth involvement. She is the link to the national Technical Assistance Partnership.	.5 FTE
Social Marketing-Communications Manager: Liz Pfisterer	Responsible for developing a social marketing/communications strategy including: a strategic plan, public education activities, and overall outreach efforts. She will also coordinate activities with the national communications campaign. The social marketing strategy will be developed to engage individuals that currently are not accessing mental health services (e.g., Native Americans and people in rural and remote areas). The business community will be engaged as part of the economic development plan for the target areas.	.5 FTE
State-Local Agency Liaison: CMHC Directors in each pilot region	Will work collaboratively with Regional Coordinators to establish interagency involvement in the project's structure and process by developing and/or changing interagency agreements and other public policies relevant to the creation of the SOC.	In-Kind
Regional Coordinator	Will serve as local fiduciary of funding for services with the goal of creating wraparound services via blended funds that meet the needs of the child and family; will establish needed interagency involvement in the project's structure and process to create a system of care that is responsive to community needs; will ensure that evidence-based practices are developed and implemented, that services provided are culturally and linguistically competent, and will establish performance standards that are monitored through a management information system. State-local agency liaisons will work in collaboration with this position.	1 FTE at each LCC

Regional Care Manager	Will work with families to identify and select a Family Care Coordinator; will partner with local Department of Family Services staff, Juvenile Probation, schools, health care providers and UPLIFT to develop a strategy for identifying and admitting youth at risk of residential placements; facilitate family outreach, advocacy, and evaluation assistance; monitor confidentiality practices and adequate consent procedures; educate communities and service partners of the mission, values, goals, and population served by the system of care in their region; work with Family Care Teams to monitor the care and services provided by service providers in their region to include: utilization of services, progress toward individualized treatment goals, re-determination of strengths, priorities, and resources, and update of the treatment plan as often as necessary; will handle grievance proceedings.	1 FTE at each LCC
Administrative Assistant	Will coordinate training of Local Coordinating Committee staff in Multi-system Therapy or Functional Family Therapy, therapeutic foster care, crisis services, cultural and linguistic competence and family focused care, Family Partnership Wraparound model, family care coordination model, system of care values and principles. Will coordinate regional system of care evaluation activities to include implementation process and outcomes, interagency collaboration, satisfaction in service provision, and cultural and linguistic competence.	1 FTE at each LCC
Family Care Coordinator	Will advocate on behalf of child/family with the service system; complete identified strengths based assessments with full participation of child/family/caretaker to determine community-based services needed to ensure health and safety in the home and community; facilitate development of multi-service community-based plan that facilitates access to clinical and non-clinical services and information, community resources, and relationships; collaborate with case managers from other service agencies; locate, arrange and refer to direct services; monitor service plan, providers, and identified outcomes (at least quarterly) to review identified goals, re-determine strengths and priorities, and resources and update the plan as needed; monitor child and family satisfaction of services and establish an open forum for the expression of concerns and disagreements and act as child/family first contact for complaint/grievance process; coordinate transition and referrals moving from one setting to another; complete case records; maintain required training competencies to include: Family Partnership Wraparound model, Individuals with Disabilities Education Act, Wyoming Special Education Rules and Regulations, effective advocacy, children's mental health disorders, knowledge of regional services, Multi-system Therapy or Functional Family Therapy, therapeutic foster care, crisis services, cultural and linguistic competence and family focused care, and system of care values and principles.	At least 1 FTE at each local site

Timeline of Activities

Year	Main Tasks
1	1. Development of services and building the organizational components for a successful comprehensive service system. 2. Begin the development of funding and administrative practices designed to provide incentives to keep youth in the community (e.g., home-based community waiver), provide the right types of services in the right amounts to meet consumer needs, use effective/cost efficient services, and to invest resources in front-end, preventive services. 3. Monthly Steering Committee meetings. 4. Develop and release RFQ. 5. Facilitate application process. 6. Establish LCCs and funding positions for each. 7. UPLIFT will recruit and train staff to fill the positions of Family Advocate/Mentor in each LCC. 8. Develop and sign contracts for wraparound and service delivery training. 9. Intensive wraparound training to orient local providers, advocates, and other stakeholders. 10. Evaluate each of the children and youth placed out of the region and develop recommendations for placement and services for each child. 11. LCC, local DFS staff, Juvenile Probation, local schools, local health care providers and the local Family Support Organization (UPLIFT) will develop a strategy for identifying and admitting children and youth at risk of residential placement.
2	1. The SOC-SC will continue taking action to eliminate barriers at the policy level to successful system of care development. 2. Seek a Home and Community-Based Medicaid Waiver. 3. Implementation in the first pilot sites will occur. 4. Evaluation of process and outcomes regarding implementation, interagency collaboration, satisfaction with service provision, and cultural competence will also occur. 5. Evaluation reports will be produced quarterly. 6. The case-rate reimbursement system will have been implemented and cost savings will be monitored. 7. In months 6-9, the RFQ will be re-released to identify pilot sites for Year 3. Sites will be selected, hiring and training of personnel will move forward in the same manner as the previous year. 8. Training for LCC staff in Multisystemic Therapy or Functional Family Therapy, therapeutic foster care, crisis services, cultural competence, and family-focused care. 9. Establish expense reimbursement payment system.
3	This year will be much like Year 2, with the additional activities of: 1. Disseminating initial pilot site data and applying lessons learned to the expansion of system of care development in other regions of the State. 2. Toward the end of this year, plans for sustainability beyond the grant period will be further articulated. 3. Ongoing evaluation, training, and compliance with the National Evaluation will occur.
4-6	The final three years of the grant will proceed in the same manner described for earlier years. Sustainability will become a primary focus. Much of Year 6 will be devoted to producing a comprehensive system development report based on data from all subsequent years and pilot sites.